1.	11)	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
ron c	10	MEDICAL EXAMINER'S CERTIFICATE OF DEATH
POR S	DEPT.	Item 16, Film G-238 1/29/59.cac. Reg. Dist. No.
HEALIR	DEPT.	1. PLACE OF DEATH a. COUNTY 1. STATE 2. USUAL RESIDENCE (Where deceased lived. H institution: Residence before admission)
Page les.		MARYLAND O. STATE MEL B. COUNTY Harker
TE		b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest fawn) ond give pearest fawn) c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest fawn)
0 50		MONKTUN RD - XSHAWSVILLE
D. O	10	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) / d. STREET ADDRESS e. 15. RESIDENCE
Bo .	00	Route 46 NER + Taylor VES NO BY
oine oine tote		3. NAME OF First Middle Last 4. DATE Month Day Year
d'e le		(Type or print) JODN LOTOV Adams J) DEATH JANKAL 24 1959
of the		3. SEX A 6. COLOR OF RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 9. AGE (In your IF UNDER 14 EAR) IF UNDER 24 HRS
With With		WIDOWED DIVORCED BY QUY 2 1929 29 yrs. Months Days Hours Min.
d 2 d 2		10g. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11/8 IRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COLINTRY?
7982		during most at warking life, even if retired)
E		13. FATHER'S NAME
PM	-/	Tobar La Roy 4 James Tal R. 1 ad 4 may 1 a stan
ever ever		15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
S S S S S S S S S S S S S S S S S S S	•	1784, no, or unknown 1 11 year, give wer or dates of resisted 213-28-8820 TALS MOLO R. adams white Hall Fre
E SO N E		The state of the s
ad pe		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I, DEATH WAS CAUSED BY: "E > 3 (+ 4)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fy 1 (Tu)- 2 1 1 1
i in fice ron		· D/YX DUE TO
a de de de		Canditions, if any, which again to immediate cause (b)
o co co		(o), stoting the underlying DUE TO
min so.		eouse lost. (c)
Ero din		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY PERFORMED?
col	0	YES NOW
be di		20a. EXTERNAL CAUSE WAS PRIMARY TO or CONTRIBUTING D CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
f M utd		
she she	100	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, falm, 20t. (City of town) Hour a.m. 1 - 2 y 159 of wark of work of wark
e 3	12	2 mm. 1-29 1939 while of work of Rorace 146 Monkton Harford M
Pag Pri		21. I certify that I took charge of the remains described above, held an Autopsy . Inspection . Inquiry . and in my
No Se o		opinion death resulted from: Natural causes . Accident . Suicide . Homicide . Undetermined manner
S O S		Rest. Ad
for DIRE		SIGNATURE LEVELU (TOURNE M.D. CHIEF MEDICAL EXAMINER) DATE SIGNED
e ce lo	2	A. ASSISTANT MEDICAL EXAMINER []
ES. T.		EXAMINER'S GEY) (C T) (M E) DEPUTY MEDICAL EXAMINER 19
S S S S S S S S S S S S S S S S S S S		270. BURIAL CREMATION, 270, DATE THEREOF 220. NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, lown, or county) (Stote)
0 4 0 0		Burial Tanzy-59 Bethel Fradonna Harford mel
- 2		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REGISTRAR'S SIGNATURE
S A15ME 5M 2/57	(38)	martin Spund Jane Therette you DATE JAN 2 9:59
2101 2101	10	S. Tums

After 1 copy of

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hours aft

I. PLACE OF DEATH

Harford

and give naarest town)

(If outside corporate limits, write RURAL

Luclla

COLOR OR

Thomas J. Avres

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

(If Yes, give wer or detes of service)

DUE TO

DUE TO

(Yaar) (Hour)

22. I hereby certify that I attended the deceased from ... Inly ... 1.

DATE THEREOF

/6/1959

REGISTRAR'S SIGNATURE

arthur S. Huma

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY,

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

RACE

White 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even #

retired) Housewife

1/ IMMEDIATE CAUSE

190. DATE OF OPERATION

SIGNATURE

BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE

24. REC'D BY REGISTRAR

GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

218. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. TIME OF INJURY (Month) (Day)

alive on Jan 2

Harford Convaliscing

WIJ We

SINGLE, MARRIED, WIDOWED, DIVORCED,

196. MAJOR FINDINGS OF OPERATION

21b. PLACE [Home, farm, fectory,

OF INJURY street, office bldg., atc.]

While

at work

21a. INJURY OCCURRED

...., and that death occurred at.1

10b. KIND OF BUSINESS

OR INDUSTRY

16. SOCIAL SECURITY NO.

Home

COUNTY

TOWN

3. NAME OF

Female

HOSPITAL OR

STREET ADDRESS

DECEASED

(Type or Print)

13. FATHER'S NAME

(Yes, no. or unk.)

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

25. FUNERAL DIRECTOR'S SIGNATURE

Hypostatic Pneu

Chronic Cardio

CERTIFICATE

CAI	E OF DEA		Dist. No			
	2. USUAL RESIDE	ENCE (HOME) OF DECEA	SED			
MARYLAND	STATE Mary	land county Ha	arford			
LENGTH OF STAY	CITY (If outside cor	porate fimits, write RURAL and give	neerest town)			
6 Mo. X TOWN Norrisville						
	STREET ADDRESS	(if sural give locet	ion)			
no Home	Reitertal	White Ha	all RD			
as Home	(Lart)	4. DATE (Month)	(Dey) (Year)			
A	lmony	DEATH Jan.	3 19 59			
CED. 8. DATE	OF BIRTH	9. AGE lest birthdey IF Ut	NDER 1 YEAR IF UNDER 24 HRS			
Morr	1865	OR yrs. Ment	hs Deys Hours Min.			
OF BUSINESS DUSTRY	11. BIRTHPLACE (State or fo	reign country)	12. CITIZEN OF WHAT			
me	Harford Co.	Ma	U.S.A.			
	Harford Co	N NAME	U.D.A.			
	Alico	Monnia				
OCIAL SECURITY NO.	Alice	ADDRESS				
	A Form A	Ayres Fawn G	mara Da			
18. MEDICAL C	ERTIFICATION	AVIES FAWII	INTERVAL BETWEEN			
			ONSET AND DEATH			
rpostatic F	neumonia		6 Mo.			
ronic Card	io Vascular Di	89388	- 7			
OPERATION			20. AUTOPSY?			
arm, fectory,	21c. WHERE DID INJURY OCC	21D 3 10'2 1 1	YES NO			
bldg., atc.]	ZIE. WHERE DID INJURY OCC	.UKT (City of fown) {	County) (State)			
JURY OCCURRED	21f. HOW DID INJURY OCC	UR?				
Not while at work						
d from July	19.58 to J.	n. 2, 19.59 tha	at I last saw the deceased			
		causes and on the date s				
	ADI	DRESS (Street, city, town, state	DATE SIGNED			
Sorc M.D.	Forest	Hanh wa	In F 30			
NAME OF CEMETERY	OR CREMATORY	LOCATION (City, town, or co	uniyi Jan 5 19			
Ayres Cha		White Hall				

ADDRESS

72 hour funeral funeral registrar by the f law requires that the death certificate be 루.드 cate be filed with completely filled ial transit permit. death certificate be physician. and co or attending physician by the attending phy-uld be detached for use the hospital

HOSPITAL The bottom copy may be retained by FUNERAL DIRECTOR: The facerificate has been executed by death certificate assembly should PHYSICIAN ATTENDR 10A 155 A15C

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Reg. Dist. No.

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I, PLACE OF DEATH o. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 b, CITY OR TOWN (If outside corporate limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest fown) d. NAME OF HOSPITAL (If not in hospital, give street oddress)
OR INSTITUTION d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO NO 3. NAME OF 4. DATE Middle Dov Yeor DECEASED OF DEATH (Type or print) 19 0 S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years last birthdoy) Months Days DIVORCED [WIDOWED | YES. 100. USBAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) man 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17, INFORMANT Address -8090 CAUSE OF DEATH [Enter only one couse per ling for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY 20 Agras X IMMEDIATE CAUSE (0) **DUE TO** Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoling the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES NO 14 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (Stote) (County) factory, street, office bldg., etc.) Hour e. m. While Not while of work of work m 2. 21. I certify that I attended the deceased from 12 193 %, to_ 1952, that I last saw the deceased , and that death occurred at 10.257M, from the causes and on the date stated above. alive on DATE SIGNED ADDRESS (Street, city or town, state) SIGNATURE PHYSICIAN'S NAME (Type) Richards Jr. 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) 1-5-1959 Mt. Erin Cemeterv havre De Grace Md 23. FIGNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Perryville .Md

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FOR STATE HEALTH DEPT 101

for. Poge for. Poge and of Health, TO DEPUTY MEDICAL ENAMINER: This certificate shalled be executed within 24 hours after death. If any delay is necess execute the contact, writing the word "pending" in pendi in Item, 18. Give Pages 1, 2, and 3 to the funeral 4 should be and enough the Chief Medical Examiner's Office along with form PM3. Page 5 may be relatined to FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Baard, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 haurs after death.

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VII. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

-			- T -						Reg. Di	11, 140	,	
1.	PLACE OF DEATH	rford	16	MARY	1	o. STATE MATT	Where decease	b. COUNT				
	b, CITY OR TOWN [if outside corporate limits, write #URAL ond give negral town] Have de Grace					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Jarrettsville						
		E OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital									e. IS RESIDENCE ON A FARM? YES NO	
	NAME OF DECEASED (Type or print)	JOH1	rt .	Middle		AMREIN	4. DATE OP DEATH	James		Doy 8	Yeor 19 59	
5.	SEX		-	D NEVER MARRIED	8.0	ATE OF BIRTH		P. AGE In years last birthday	The second secon	-	IF UNDER 24 HRS.	
	Male	White	WIDOWED	DIVORCED 1	D J	une 15. 1	1908	50 yrs.	Months D	Poys	Hours Min.	
13	ruck Dri FATHER'S NAME Charles WAS DECEASED EVE	g life, even if retired)	Ha RCES? 16.	ind of Business or in the control of	Inty	Jarrett 4. MOTHER'S MAIDEN Mary A. DRMANT	Esvill	e Md.	II.	S.J	A .	
ATION	Conditions, if or gove rise to immed (e), sloting the couse lost.	inderlying DUE TO	Myoc	ardial Info	erosi		AINAL DISEASE	CONDITION GIV	'EN IN PART	1(a) 11	P. WAS AUTOPSY PERFORMED?	
L CERTIFICATION												
MEDICAL	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While Not while of work of two of tw											
	21. I certify that I taak charge af the remains described abave, held an Autopsy X, Inspection [], Inquiry [], and in my opinion death resulted from: Notural couses X. Accident [], Suicide [], Homicide [], Undetermined manner [] ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER [] 1/8/59											
-	EXAMINER'S NAME (Type)	Russell	S. Fi	isher, M.D.	-	DEPUTY MEDICAL	EXAMINER [)				
72	Burial CREMATIO REMOVAL (Specify)		F	Wm . Wa.t		REMATORY	1 ~	town	or county)		(Stole)	
23	FUNERAL DIRECTOR	S SIGNATURE	to h	ADDRESS Farrelles	rell		JAN 1 2 1	RAR 24b. REGI	strar's sign		E	

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ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page Party	Hotel Poge The
retained the haspital or attending physician.	と
RAL DIR. OR: After this certificate has been signed by the otherding physician and campletely filled in by	eral director,
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shazig be filed with	be filed with
stron prior to burial, cremotion, or removal, and in one event within 72 hours after death.	,

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

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				100	eg. Dist. 110.	
1. PLACE OF DEATH o. COUNTY	- 11 /	USUAL RESIDENCE (Who	ere deceased live	d. If institution	Residence befor	re odmission)
Harford	YLAND	Marv	land	a COUNTY	Harfor	đ
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Y IN th	c. CITY OR TOWN (IF or	ulside corporale	limits, write RURA	L and give nea	srest town)
Havre de Grace D.O.A.		Edge	wood R	ıral		
d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?
Harford Memorial Hospital		Norris	's Corn	er		YES [] NO [
3. NAME OF First Middle DECEASED	e	Lost	4. DATE OF	Month	Do	y Year
(Type or print) Willem H.	. B	earsch	DEATH	Jan.	6	, 19 59
5. SEX 6. COLOR OR RACE 7. MARRIED 1 NEVER MARRI	(IED 🔲 8. D/	ATE OF BIRTH	9. 4			IF UNDER 24 HRS
male white WIDOWED DIVORCE	_ ,	Aug.20.1907		51 yrs.	anths Days	Haurs Min.
100 USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS C during most of working life, even if retired)	OR INDUSTRY	11. BIRTHPLACE (State of	or fareign countr	γ)	12 CITIZEN O	F WHAT COUNTRY
Merchant Gen. Mdse.		Edgewood	Maryla	nd	U.S	.A.,
13. FATHER'S NAME	14	. MOTHER'S MAIDEN N				
Geroge Bearsch		Annie G	unther			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO [Yes, no. or unknown] [If yes, give wor or detex of service]	O. 17 INFOR	RMANT		Address		
218-32-0822	2 Mor	rell H. Bea	rsch, E	lgewood,	R.D., M	aryland
18 CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).).]		1			RVAL BETWEEN
PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0)	nu	ocaln	and	2	ONS	SET AIND DEATH
420.1 DUE TO	/	-				- wy
Canditians, if ony, which }						
gave rise to immediate						
lying cause last.						
	EATH BUT NOT	RELATED TO THE TERMIN	NAL DISEASE CO	NDITION GIVEN	IN PART 1(o) 1	9. WAS AUTOPSY
22						PERFORMED? YES NO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DE. 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	OCCURRED. (En	nter nature of injury in Pa	art I or Part II o	f ilem 18.)		
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED	20e. PLACE C	OF INJURY (Hame, farm,	20f. (City or t	awn)	(County)	(State)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Nat white at work at work	roctory,	street, office bldg., etc.)				
21. I certify that I attended the deceased from 1 - 4	-{	, 19 5 710 1	-6	19 5 51	hat I last so	w the deceased
	t death acc	orred at 8P.				
				city or lown, stal		DATE SIGNED
SIGNATURE Therald & Jahne	M.D.			Maryland		
PHYSICIAN'S						
NAME (Type) Gerald C. Palmer		B	el Air.	Maryland	1	
220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEM				(City, Iown, or co		(State)
Burial Jan.9,1959 Trinity I	Luthera			, Harfor		Md.
23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	A	240 REC'D	BY REGISTRAR	245. REGISTRA	AR'S SIGNATUR	E
HUTYS K Blownsh Abingo	don, Mar	TYLENG DATE !!	5 2 59	- 1.	& House	

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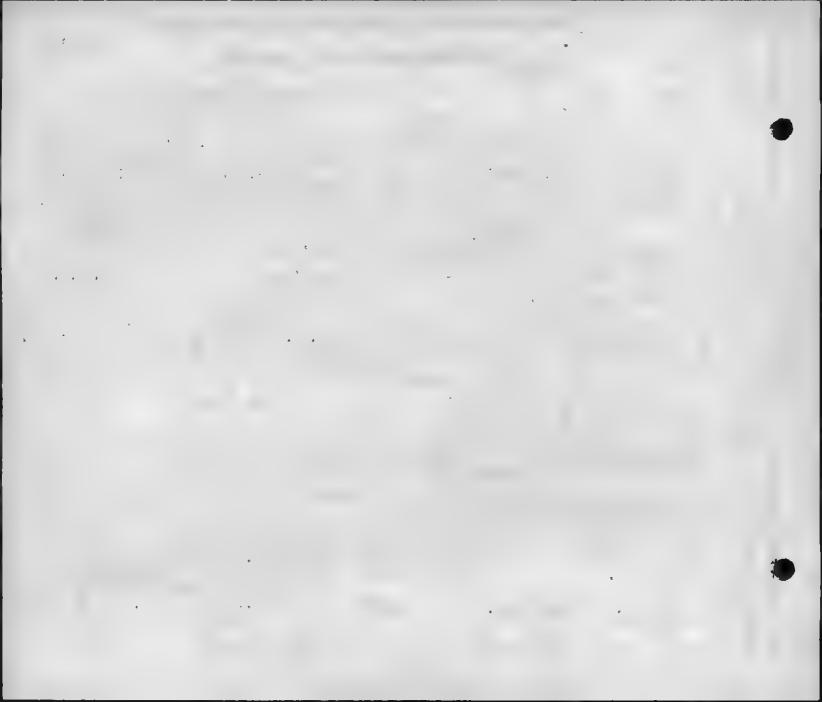
physician.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13,128

Reg. Dist. No. I. PLACE OF DEATH 2. USUAL RESIDENCE (HOME) OF DECEASED Harford Harford Maryland COUNTY STATE COUNTY MARYLAND (If outside corporate limits, write RURAL LENGTH OF STAY (If outside corporere parties and give neerest town) RURAL, Bel Air (If outside corporete limits, write RURAL and give nearest town) (in this place) TOWN 5 months TOWN RURAL - Bel Air HOSPITAL OR STREET (If rural give location) INSTITUTION OR ADDRESS CO Ernest B. Kirkpatrick, RFD #2, Bel Air (Middle) (Last) 3. NAME OF Christiania DATE DECEASED January 3. (Type or Print) CHRISTIANA CATHERINE **BEVANS** DEATH S. SEX COLOR OR SINGLE, MARRIED. 8. DATE OF BIRTH 9. AGE lest birthdey IF LINDER 1 YEAR IF UNDER 24 HRS RACE W WIDOWED, DIVORCED, F November 18, 1876 (Specify) WI dow 10+. USUAL OCCUPATION (Give kind of work 106. KIND OF BUSINESS 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT done during most of working life, even if OR INDUSTRY COUNTRY? retired housewife Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Harman Schlissler Catherine Kate 17. INFORMANT & ADDRESS SOIT - IT- I TW: IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unk.) Ilf Yes, give wer or dates of servicel E. B. Kirkpatrick, RD #2, Bel Air, Md. no 18. MEDICAL CERTIFICATION INTERVAL BETWEEN I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONSET AND DEATH Congestive heart failure 1 hours IMMEDIATE CAUSE DUE TO ANTECEDENT CAUSE(S) Arterioscierotic cardiovascular disease several years DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING recent cerebral thrombosis fracture of right hip 2 or 3 weeks TO THE DEATH BUT NOT RELATED TO THE 6 months DISEASE OR CONDITION CAUSING DEATH 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20 AUTOPSY 7 NO X 21a. ACCIDENT WAS UNDERLYING 21b PLACE (Home, farm, fectory, 21c. WHERE DID INJURY OCCUR? (City or town) [County] (Stein) OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. TIME OF INJURY (Month) (Day) 21e. INJURY OCCURRED 21f. HOW DID INJURY OCCUR? (Yeer) (Hour) While Not while et work 22. I hereby certify that I attended the deceased from August 24 10 58 to Jan. 3 19.59 that I last saw the deceased sth certificate a alive on DeCa. 30 19.56 , and that death occurred at 12:500M, from the causes and on the date stated above 23 (BURIAL) CREMATION, DATE THEREOF ADDRESS (Street, city, town, state) 115 Fulford Ave., Bel Air, Md. Jan. 3, 159 NAME OF CEMETERY OR CREMATORY. LOCATION (City, town, or county) (State) 24. REC'D BY REGISTRAR REGISTRAR'S.SIGNATURE 25, FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** JAN 6



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

(4) (5)

699 Reg. Dist. No.... 1. PLACE OF DEATH 2. USUAL RESIDENCE (HOME) OF DECEASED Harford COUNTY Maryland MARYLAND STATE county Harford (If outside corporete limits, write RURAL LENGTH OF STAY (If outside corporate limits, write RURAL and give nearest town) and give nearest town) (in this piece) TOWN RURAL -- Forest Hill RURAL - Forest Hill HOSPITAL OR STREET (Il rural give location) Box 215, RFD. Forest Hill INSTITUTION OR ADDRESS Box 215, RFD, Forest HIII STREET ADDRESS 3, NAME OF (First) (Middle) (Lesi) 4. DATE (Month) (Dey) [Year] DESCRIPTION OF REAL PROPERTY. (Type or Print) JAMES DEATH January 31 HENRY BLAKE 6. COLOR OR 7. SINGLE, MARRIED B. DATE OF BIRTH 9. AGE last birthday IF UNDER I YEAR HE UNDER 24 HRS WIDOWED, DIVORCED Hours male October 29, 1877 (Specify) married 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS 11. BiRTHPLACE (State or foreign country) CITIZEN OF WHAT done during most of working life, even if OR INDUSTRY COUNTRY? Farmer Farmine Maryland U. S. A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Blake Martha O'Donnell 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17. INFORMANT & ADDRESS 16. SOCIAL SECURITY NO. Box 215, RFD, (If Yas, give wer or dates of service) (Yes, no, or unk.) 219-36-021/ Alvin Blake (son) Forest HIII. no 18. MEDICAL CERTIFICATION INTERVAL BETWEEN I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONSET AND DEATH Myocardial Infarction 4mull IMMEDIATE CAUSE DUE TO ANTECEDENT CAUSE(S) Coronary thrombosis hrs. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO the attached STATING UNDERLYING CAUSE LAST. Arteriosclerotic cardiovascular disease 5 yrs. (0) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE Residual of cerebrovascular accident 18 months DISEASE OR CONDITION CAUSING DEATH.

21a. ACCIDENT WAS UNDERLYING FT OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, ferm, fectory, OF INJURY street, office bidg., etc.)

19b. MAJOR FINDINGS OF OPERATION

21c. WHERE DID INJURY OCCUR? (City or lown)

(County)

(Harford

20. AUTOPSY? NO [(State)

21d. TIME OF INJURY (Month) (Day) (Yeer) (Hour)

21a. INJURY OCCURRED Not while at work at work

21. HOW DID INJURY OCCUR?

22.	I he	reby	certif
	alive	оп	

19a. DATE OF OPERATION

y that I attended the deceased from Jan.

evile	оп,	19,	ind that dea	sth_occurred	at 12:05 M	from the	causes an	d on the d	late stated	above
BIGN	ATURES House	Te a the	risue	Palm	M)	, ADI	DRESS SI	real, city, low	n, stote)	D
Pai	III S. Stones	far In	Dobut	- Nedy	UT IELEK, PY	ord A	man man	JATH.	CHOPEN	151

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, Jown, or county)

(Stata) Md.

ATE SIGNED

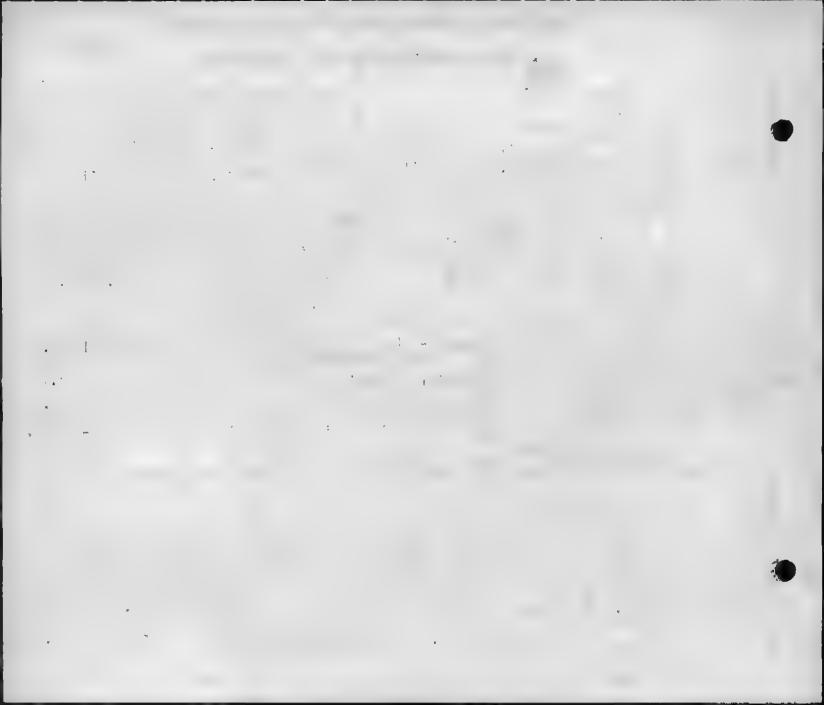
Eur le l 24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

1959 St. Ignatious Cemetary Hickory 25. FUNERAL DIRECTOR'S SIGNATURE W. Brondway + Williams St. BEI Air, manyond

DATE FEB 3

TOR: The laxecumd t DIRECTOR: certificate assembly c≡py may FUNERAL certificate death



₹.s

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with certificate has been executed by the attending physician and completely filled death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

	keg. Dist. No
1. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECEASED
COUNTY Harford MARYLAND	STATE 1 - 0 32 d COUNTY Toford
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town)	CITY (If outside corporate limits, write RURAL and give nearest lown)
TOWN Fallston 15 yrs	X TOWN Followton RD
HOSPITAL OR	STREET (If guret give location)
INSTITUTION OR STREET ADDRESS	/ ADDRESS
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month) (Day) (Year)
DECEASED	OF
Cora Leedinga R	levins • 1 Jan 7 1950
RACE WIDOWED, DIVORCED,	Months I Borre Marrie Life
Female Phite (Specify) 120Wed Co	t. 15, 1871 87 yrs. Monins Days Mours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if OR INDUSTRY	11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT
refired) TO 135 Wills. Home	Transing Transition
13. FATHER'S NAME	Lansing II. 7.
Dol ant Dansi.	
Tobert Princis 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO	Start 17. INFORMANT & ADDRESS
(Yes, no, or unk.) (If Yes, give war or dates of service)	
()	Miss. Francis Blovins Fallsto
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
Consor	
	tive Heart Failure 3 weeks
ANTICEPENT CAUSELS!	e Thoraco-Lumbar Kyphosis Prob. 10 yr
GIVING RISE TO THE ABOVE CAUSE	A ZHOTACO-ZUROGI AVOROSIS ZIOD, 10 VI
	Arthritis 32 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	7,000
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
194. DATE OF OPERATION 196. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	YES NO
21e. ACCIDENT WAS UNDERLYING ☐ ? 21b. PLACE (Home, farm, factory, OR CONTRIBUTING ☐ CAUSE OF DEATH OF INJURY street, office bidg., etc.) (IF EITHER, NOTIFY MEDICAL EXAMINER)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Yasr) (Hour) 21e. INJURY OCCURRED While Not while at work at work at work at work	21f. HOW DID INJURY OCCUR?
	3, 19.59, to Jan.7, 19.59, that I last saw the deceased
	d at.5
SIGNATURE	ADDRESS (Street, city, lown, stete) DATE SIGNET
Color Barthy A M.O.	Forest Hill, Maryland Jon. 7, 19
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY	OR CREMATORY LOCATION (City, town, or county) (State)
Burial 1/9/1959 Oak Gro	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE	
DATE JAN 12 J	Million Silver & gum Heell



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

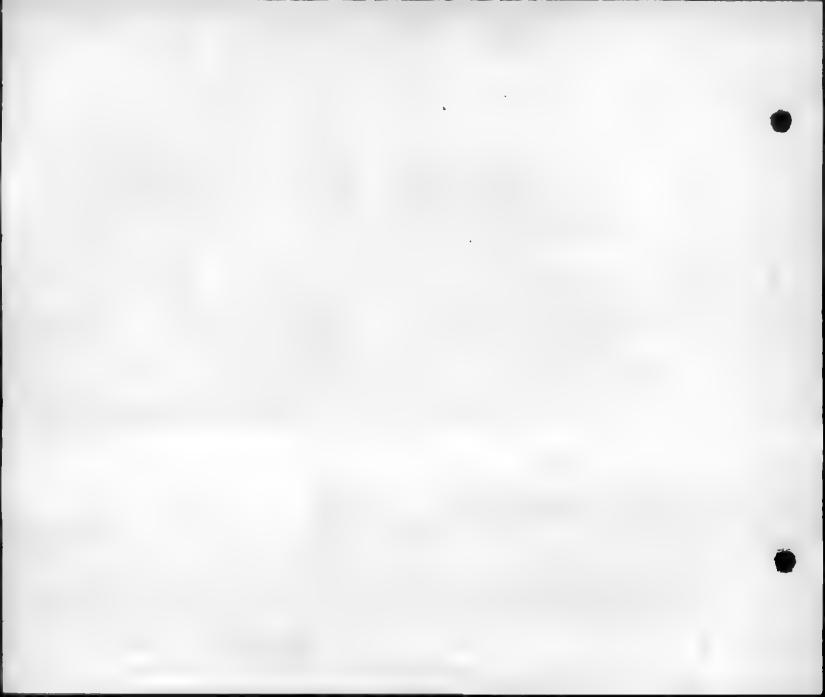
701 CERTIFICATE OF DEATH

00671

				· · · · · · · · · · · · · · · · · · ·			
1	1. F	COUNTY Harland	MARYLAND	2. USUAL RESIDENCE (WHO O. STATE	b. COUNT	tion Residence before admission	n)
1		o. CITY OR TOWN (If objecte corporate limits, write RURAL and gire negrest town).	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF o	Bel air 1	RURAL and give nearest town]	
7	· ·	d NAME OF HOSPITAL (If not in haspital, give street or INSTITUTION BELLIUM	oddrest	STREET ADDRESS		e IS RESID ON A F YES	FARM?
		NAME OF DECEASED (Type or print) First Dennis	Middle	Bradley	4. DATE OF DEATH	onth Day Ye	59,
	5. 5	CEX 6. COLOR OR RACE 7. MAR Wale white WIDOW	RIED NEVER MARRIED	8. DATE OF BIRTH DEC17-18	9 AGE (In years fest birthday) 4 yrs	Months Days Hours	24 HRS. Min.
1	L	USUAL OCCUPATION (Give kind of work dane) 10b during most of working life, even if retired)	later Compe	STRY 13. BIRTHPLACE (Stole	or foreign country)	12 CITIZEN OF WHAT C	OUNTRY
)		FATHER'S NAME Daniel /	Bradley	14. MOTHER'S MAIDEN N	ame Jaha	ney.	
	(Yes	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. no. or unknown) (If yes, give wor or dates of service)	SOCIAL SECURITY NO. 17. 1 15-63-3259	Mrs alice	U. Bruch	y-Bolair	me
		18. CAUSE OF DEATH [Enter only one couse per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		P. FAILUBE		INTERVAL BETY ONSET AND D	HTABC
			VAN: ED FATT	TRIOSPIE ROS	s + con 60	557108	
		gove rise to immediate couse (a), stating the under-		HUART FA	160' RE	2 464	ias
0	ICAT ON	PAIT II. OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMIN	NAL DISEASE CONDITION GI	IVEN IN PART 1(a) 19 WAS AL PERFOR! YES [MED?
	L CERTIF	20g ACCIDENT WAS UNDERLYING 20b. DE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	SCRIBE HOW INJURY OCCURRE	D. (Enter noture of injury in P	ort I ar Port II of item 18.)		,
	MEDICAL	Hour o.m. White	fa.	ACE OF INJURY (Home, form, ctary, street, office bldg., etc.	20f. (City or town)	(County)	(Slote)
		21. I certify that I attended the decea	Mr. Link	. " 192	4)	Z,that I last saw the d	
		ACTUAL SIGNATURE HERE	will		ADDRESS (Street, city or town		E SIGNED
1		0 1100-	MILL M.D.				
	220	BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify)	22c. NAME OF CEMETERY O	R CREMATORY	22d LOCATION (City Jown,	or county) (Stote)	
3	23	FUNERAL DIRECTOR & SIGNATURE H. arche	ADDRESS Benson	240. REC'S	BY REGISTRAL 24b. REG	ISTRAR'S SIGNATURE	

may be retaint he hospital ar attending physician.

TO FUNERAL DIMERAL PART HIS After this certificate has been signed by the attending physician and campletely filled in by interest director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, crematian, or remaval, and in any event within 72 hours after death. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 TO HOSPITAL OR VS A15 (4) 1SM 9/SS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) · COUNTY o. STATE **b.** COUNTY MARYLAND OP CITY OR TOWN (If outside corporate limits, write c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) c. LENGTH OF STAY IN 16 RURAL and give nearest town) d NAME OF HOSPITAL (If not in Hospital, give street address) d STREET ADDRESS OSINSTITUTION 4. DATE OF DEATH Middle Month Dov Year DECEASED (Type or print) 9. AGE (In years last_bigthday) 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH Months Doys DIVORCED -WIDOWED IS USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY) BIRTHPLACE (State at foreign caunity) during most of working life, even if retired) HOUSEWIT 14. MOTHER'S MAIDEN NAME

director, H 8 pluous e. IS RESIDENCE ON A FARM? MAKTOR YES NO D NAME OF 19 5 IF WINDER I YEAR IF UNDER 24 HRS 5 SEX 12 CITIZEN OF WHAT COUNTRY? offer 13 FATHER'S NAME IKAM 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17_INFORMANT CAUSE OF DEATH [Enter only one cause per Line for (a), (b), and (c) INTERVAL BETWEEK PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) 6666 443 X DUE TO Canditions, if ony, which gave rise to immediate **DUE TO** couse (o), stating the underlying couse lost. burial-transit PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPSY PERFORMED? YES 🔲 NO 🔃 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, | 20f. (City or town) (Stole) (County) factory, street, office bldg . etc.) Hour O. III While Not while of work That I last saw the deceased 21. I cortify that I attended the deceased fram alive on. and that death occurred M. fram the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE/SIGNED ACTUAL SIGNATURE Prior should PHYSICIAN'S registror NAME (Type) 62 220 AURIAL CREMATION. 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION ICIN. lown, or county) (Stote) REMOVAL (Specify) 23 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240 REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE DATE

c physician death certificate attending ò ö etoir At D FUNER 0 VS A15 (4) 15M 9/55

death,

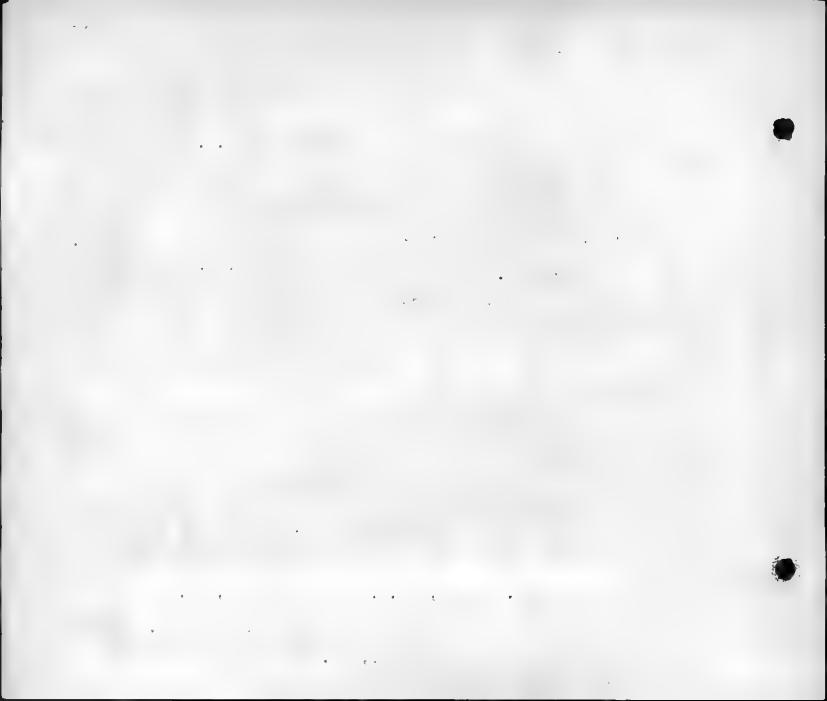


director Page PLACE OF DEATH filed o. COUNTY MARYLAND deoth. erol CITY OF TOWALIF outside carparate limits, write c. LENGTH OF STAY IN 15 151 8 RURAL and give gearest town ъ d NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS OR INSTITUTION puo Ē NAME OF 4. DATE Middle OF (Type or print) DEATH 6/ COLOR OR BACE 7. MARRIED | MEVER MARRIED DATE OF BIRTH completel WIDOWED T DIVORCED-USUAL OCCUPATION (Give kind of work done 106 BIND OF BUSINESS OR IMPUSTRY (State or life an coentry) during most of working life, even if retired) puo carbon ofter 13 FATHER'S NAME MAIDEN NAME 14 MOTHER physicion геттоме hours WAS DECEASED EVER IN U. S ARMED FORCES? 16 SOCIAL SECURITY NO JINFORMANT ending 72 CAUSE OF DEATH [Enter only one couse per line for (o), (b), and ā PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO ģ Dermit. any Canditions, if ony, which (b) gned gove rise to immediate **DUE TO** cause (o), stoting the underpup lying couse lost (c). 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 50 MEDICAL 20e. PLACE OF INJURY (Home, form, 20f (City or town) 20c TIME OF INJURY Month. Doy, Year 20d INJURY OCCURRED factory, street, office bldg., etc 1 Hour 0. m While Not while p. m at work 🔲 ot wark 21. I certify that I offended the deceased from WALLY Lan alive on and that death occurred of ACTUAL Prior 0 shoul Ale PHYSICIAN'S NAME (Type) he registrar noy be r FUNER 3 220 BURIAL GREMATION 226 22c NAME OF CEMETERY OF CREMATORY page REMOVAL (Specify) 0 23 FUMERAL DIRECTOR'S, SIGNATURE ADDRESS 240 REC'D BY REGISTRAR VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** Reg. Dist. No. 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY c CITY OR TOWN (V outside corporate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? YES NO Month Day Yeor 19 AGE (In years IF UNDER TYEAR IF UNDER 24 HPS last birthday) Months Days Hours Min 12, CITIZENLOF WHAT COUNTRY? Address INTERVAL BETWEEN ONSET AND DEATH PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS ALTOPSY PERFORMED? YES [NO X 206 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) (State) (County) 1959, that I last saw the deceased M, from the couses and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 22d LOCATION (City, toyo, or county) (State) 24b. REGISTRAR'S SIGNATURE



1 7		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18	
D		675 CERTIFICATE OF DEATH Reg. Djst. No. 1 67	(d.
srol director	1. Pi	COUNTY Las fard MARYLAND 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission of STATE Maryland b. COUNTY far far	n)
- The same of the	b	CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
2 shauld	7 d	NAME OF HOSPITAL II not in hospital, give street oddress] of Institution of Marian Address of Street Address AXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	ARM?
p out		ME OF CEASED PE OF PIETE WAXXX First Lankley Caller DEATH Contract 19	-
S. Pogg	5. SI		
o completion of popers.	100	ISUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State ar foreign country) Local Mines Coal Mines Local Mines	OUNTRY?
carbon pro	13 F	THER'S NAME Creed F. Collier Willie Ann Edens	
ng physicion rs remove car 72 hours off	15. V (Yes.	AS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT NO 19 yes, give wor or doing of service) 233 09 9317/k skard College gion 158 & Mary St.	Fredu
offending n please re 1 within 72		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) CArter om atak (frimary ONSET AND D	WEEN PEATH
d by the mit. The		Conditions, if any, which) (b) rectan status remate reference 18 m	6.
d per		gave rise to immédiate ausse (a), slating the <u>under-</u> DUE TO ying cause last. (c)	
uniol-tronsi	CATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AU PERFORALY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (0) 19. WAS AUTOMATICALLY ESTABLISHED TO THE TERMINAL DISEASE CONDITION GIVEN DISEASE CONDITION	MED?
the bu		Do ACCIDENT WAS UNDERLYING TO 20th DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of I em 18.) R CONTRIBUTING CAUSE OF DEATH FEITHER, NOTIFY MEDICAL EXAMINER)	
r use or	MEDICAL	C TIME OF INJURY Month, Day, Year Hour a. m. P. m. 19 A INJURY OCCURRED While of work at wor	(Stole)
: Affer ched fo vrial, c	1 1	1. I certify that Vattended the deceased from 10 10 10 10 10 10 10 10 10 10 10 10 10	
be deto		ADDRESS (Street, city or town, state) a DATI	E SIGNED
3 should gistrar pr		HYSICIAN'S Peter P. Rodman, M.D. Aberdeen, Md.	
Poge 3	220.	URIAL CREMATION, 22b. DATE THEREOF EMOVAL (Specify) Purial 1/11/59 Bel Air Memorial Gardens, Bel Air, Maryland	
15 (4) 9/55	23. F	ADDRESS ADDRES	
	1	Tarring Funeral Home	



director,

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complet papers.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

F DEATH

22c NAME OF CEMETERY OR CREMATORY

		703	CERTIF	ICATE O
1.	PLACE OF DEATH o. COUNTY Ha	rford	MARYL	AND 2. USUAI
	RURAL and give ne	outside corporate limits, writerest town) roving Ground	120	all c. cir
		AL (If not in hospital, give stre	to a second second	d sti
3		Rose Baxter	Middle Cunningham	
5.	SEX	6 COLOR OR RACE 7. M.	ARRIED NEVER MARRIED	8. DATE OF
	Female	Caucasian wind	OWED DIVORCED	□ 14 De
10	during most of work	ON (Give kind of work done I ing life, even if retired)		INDUSTRY 11 BI
13	. FATHER'S NAME	18		14. MO1
		phus Baxter		
(Y	NO NO	R IN U. S. ARMED FORCES?	16. SOCIAL SECURITY NO	LtCol F
	IB. CAUSE OF DEA	TH [Enter only one couse pe	r line for (a), (b), and (c).]	
	PART I. DEAT	TH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO	Intracerebra	l hemori
	Conditions, if or gove rise to in couse (a), stating t	nmediate (Metastatic o	earcinoma
	lying couse lost.	(c)	Carcinoma of	breast
202	PART II. OTH	ER SIGNIFICANT CONDITION	S CONTRIBUTING TO DEAT	H BUT NOT RELA
5	Meg	aloblastic an	emia	
CERTIFI	200 ACCIDENT WAS		No injury	· ·
MEDICAL	20c. TIME OF INJURY Howr o. m.	wh.	INJURY OCCURRED 2	Oe. PLACE OF INI factory, street,
-	p. till		<u> </u>	

Reg. Dist. No. RESIDENCE (Where deceased lived. If institution. Residence before admission) b. COUNTY West Virginia Cabell OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milton. West Virginia EET ADDRESS e. IS RESIDENCE ON A FARM? Church Street YES NO 12 4. DATE January 14 10 59 DEATH AGE (in years lost buthday) BIRTH IF UNDER TYEAR IF UNDER 24 HRS Months Hours cember 1877 RTHPLACE (State or fore an country) 12. CITIZEN OF WHAT COUNTRY est Virginia USA HER'S MAIDEN NAME arah Prudence Duffv arvey M. Hardin. Aberdeen Proving Gd., Md. INTERVAL BETWEEN ONSET AND DEATH hage Unknown ED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPS! PERFORMED? YES NO. ture of injury in Port I or Part II of item 18.1 dent URY (Home, form, 20f. (City at town) (County) (State) office bldg., etc.) 21. I certify that I attended the deceased from 1 January , 1959, to Death 14 Jany 59, that I last saw the deceased Jan. 19.59..., and that death occurred at 10:10PM, from the causes and an the date stated above DATE SIGNED Aberdeen Proving Ground Maryland

22d. LOCATION (City, town, or county)

24b REGISTRAR'S SIGNATURE

(Stote)

page 3 shauld O FUNERAL VS A15 (4) 15M 10/57

ACTUAL SIGNATURE

PHYSICIAN'S

NAME (Type) 220. BURIAL CREMATION.



1	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18			
D L	676	CERTIFICATE OF D	EATH	(1) 676 Reg. Dist. No.
Ī	PLACE OF DEATH COUNTY HAR FORD	MARYLAND 2. USUAL RESID		If institution: Residence before admission) COUNTY HARFORD
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) HAJRE OF ORACE IHR. SOMO. BEING			
71	d. NAME OF HOSPITAL (If not in hospitol give street oddres OR INSTITUTION		DRESS	e. IS RESIDENCE ON A FARM? YES NO
3	NAME OF DECEASED (Type or print) HERBERT	J Middle DAVI	4. DATE OF DEATH	Nonth Day Year 7ANUARY 281954
5	SEX 6. COLOR OR RACE 7. MARRIED WIDOWED 1	NEVER MARRIED B DATE OF BIRTH	9. AGE 1901 57	(In years IF UNDER FEAR IF UNDER 24 HRS birthday) Wonths Days Hours Min.
Ī	or USUAL OCCUPATION (Give kind of work done 10b. KIND during most of working life, even if retired)	OF BUSINESS OR INDUSTRY 11. BIRTHPU	CE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
A. 1	13 FATHER'S NAME RILEY DAVIS 14. MOTHER'S MAIDEN NAME DILLY COBIE			
	You can be surknown? . All was much wor as dotes of sarrical	17. INFORMANT 09-7743 Mrs. Anna	Davis	Address Bel Air, Maryland.
	18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Interoculty at higherarchial in farmer of the period of the pe			
	Conditions, if any, which) and itensely titue out to to			
	gave rise to immediate couse (a), stating the under lying couse last. DUE TO Artifit to the rette Caretie variety of the rest of the retter of the rest of the retter of the rest of the			
	PART IS. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AUTOPSY PERFORMED? YES NO L			
	200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port 11 of Stem 18.) OR CONTRIBUTING CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER)			
	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY While at work	OCCURRED Not white foctory, street effice	lome_farm, 20f. (City or tow bldg., etc.)	n) (County) (State)
	21. I certify that Lattended the deceosed from the 28th, 19 19, to 2000 M. from the couses and on the dote stated above.			
	ACTUAL SIGNATURE TEE TO THE TEE TO THE SIGNATURE ADDRESS (Street, city or town, stole) ACTUAL SIGNATURE ACTUAL SIGNATURE ACTUAL SIGNATURE ADDRESS (Street, city or town, stole) ACTUAL SIGNATURE ACTUAL SIGN			
/	PHYSICIAN'S Edicade C. Loo, M.D. Harri Cli Epiere Put.			
	Burial Feb.1.1959	NAME OF CEMETERY OR CREMATORY Mt. Zion	Bel Air	
2		ADDRESS .ngdon, Maryland.	240. REC'D BY REGISTRAR DATES 2 753	24b REGISTRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 704 **CERTIFICATE OF DEATH** Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. COUNTY b. COUNTY MARYLAND Harford Maryland Harford b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] RURAL and give nearest town) High Point High Point d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION .= NAME OF Middle 4. DATE Last Month DECEASED (Type or print) DEATH Frank Oliver FORTO January 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED T 9. AGE (In years lost birthday) FUNDER I YEAR IF UNDER 24 HRS B. DATE OF BIRTH Months DIVORCED | WIDOWED T popers. Male White YES 10a, USUAL OCCUPATION (Give kind of work dane lob. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? corbon pop U.S.A. Farming Pleasantville Md 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician Oliver S. Foard move Marv Harkins 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 116. SOCIAL SECURITY NO. 17. INFORMANT Address 215-36-8099 Russell Forest 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] ā PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Lobar Pneumonia, terminating DUE TO Conditions, if any, which (b) gove rise to immediate DUE TO cause (o), stating the under-Cerebral hemorrhage lying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(1) 19. WAS AUTOPSY 200. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, Day, 20d. INJURY OCCURRED 20f. (City or town) factory, street, office bldg., etc.) O. ft. While Not while of work of work 19.58, to Jan 11 , 19.59, that I last saw the deceased 21. I certify that I attended the deceased from Feb. 7 glive on Jan. and that death occurred at 4:00 A.M. from the causes and an the date stated above ADDRESS (Street, city or town, state) ACTUAL PHYSICIAN'S Willard P. Hudson V.D. NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or county) REMOVAL (Specify)

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23. FUNERAL DIRECTOR'S SIGNATURE

Centre

ADDRESS

IS RESIDENCE

Day

13

Davi

ON A FARM? YES W NO [

Year

19 59

M.a.

Hours

INTERVAL BETWEEN ONSET AND DEATH

days

PERFORMED? YES NO

(Stote)

DATE SIGNED

(Stole)

Ldavs

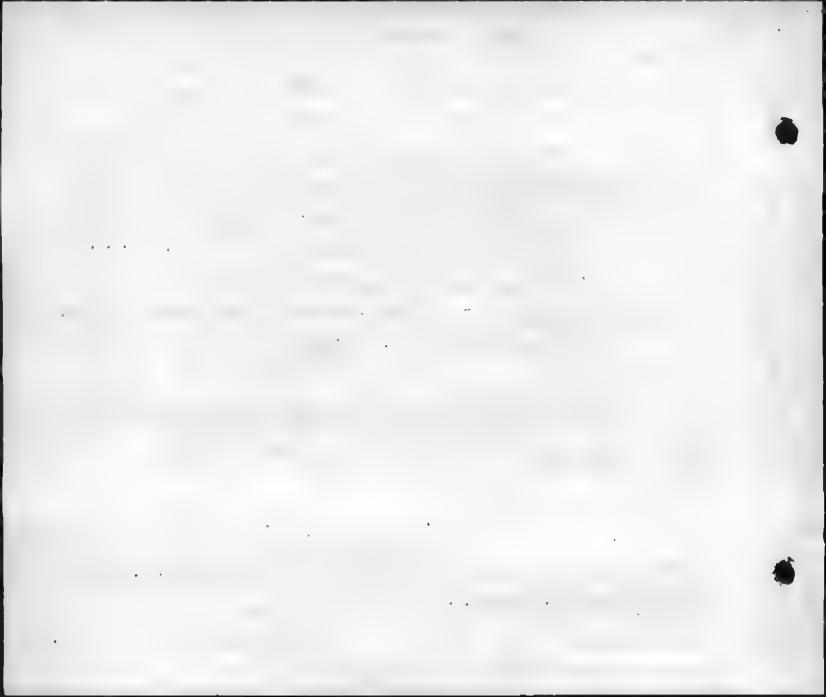
(County)

24b. REGISTRAR'S SIGNATURE Cather S. Trava

Fancet

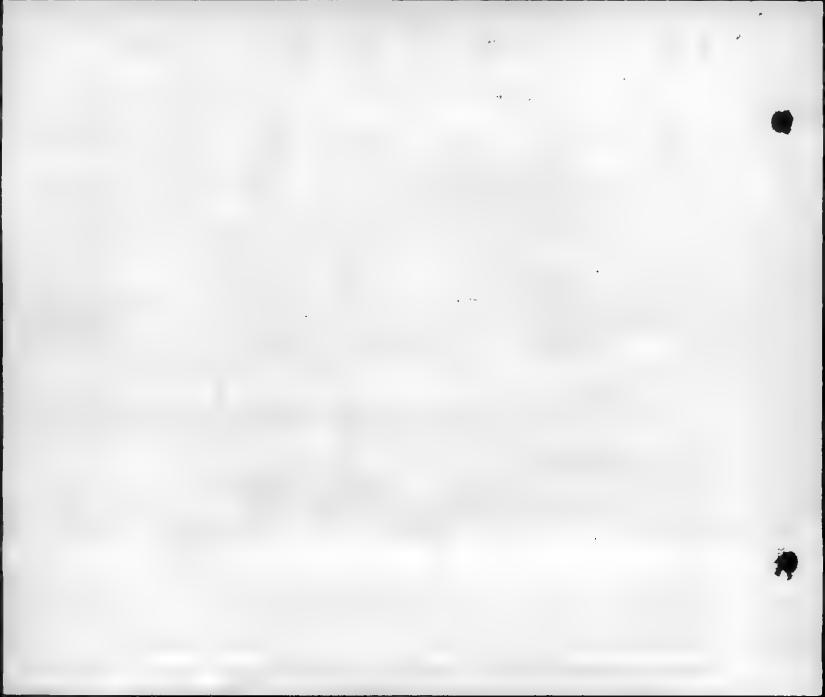
240. REC'D BY REGISTRAR

15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** 705 Ren. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) n. COUNTY **b.** COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negres) town) RURAK and give nearest town) d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE OF INSTITUTION ON A FARM? 200 YES TO NO TO puc NAME OF 4. DATE Middle last Month Day Year DECEASED OF DEATH (Type or print) NATE TIAN 19 5 5 SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9 AGE (In years IF UNDER TYEAR IF UNDER 24 ITES MARRIED NEVER MARRIED lost birthday) Months Dovs WIDOWED | DIVORCED [100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) US.00 11/16 carbon offer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician 1200 move (IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address arest attending 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ä ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) MINISTES 11.16 X DUE TO å been signed by transit permit. ony Conditions, if any, which gave rise to immediate DUE TO cause (o), stating the underlying couse last. burial-transit PART IL. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY remayal, PERFORMED? YES TO NO TO 20d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port II of item 18.) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (State) Ø. /1. foctory, street, office bldg., etc.) While Not white at work | at work p. m. 19.55, to 3/ 5/04, 1959, that I last saw the deceased 21. I certify that I attended the deceased from Sept and that death occurred at 745 x M, from the causes and on the date stated above. 30 ADDRESS (Street, city or town, state) **ACTUAL** prior SIGNATURE PIRKETISLIL.L 3 should PHYSICIAN'S TO FUNERAL NAME (Type) 22b. DATE THEREO! 220. BURIAL, CREMATION. 22c. NAME OF CEMÉTERY OR CREMATORY 22d. LOCATION (City, town, or county) pode (State) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24b. REGISTRAR'S SIGNATURE 24o. REC'D BY REGISTRAR VS A15 (4) 15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

707 CERTIFICATE OF DEATH

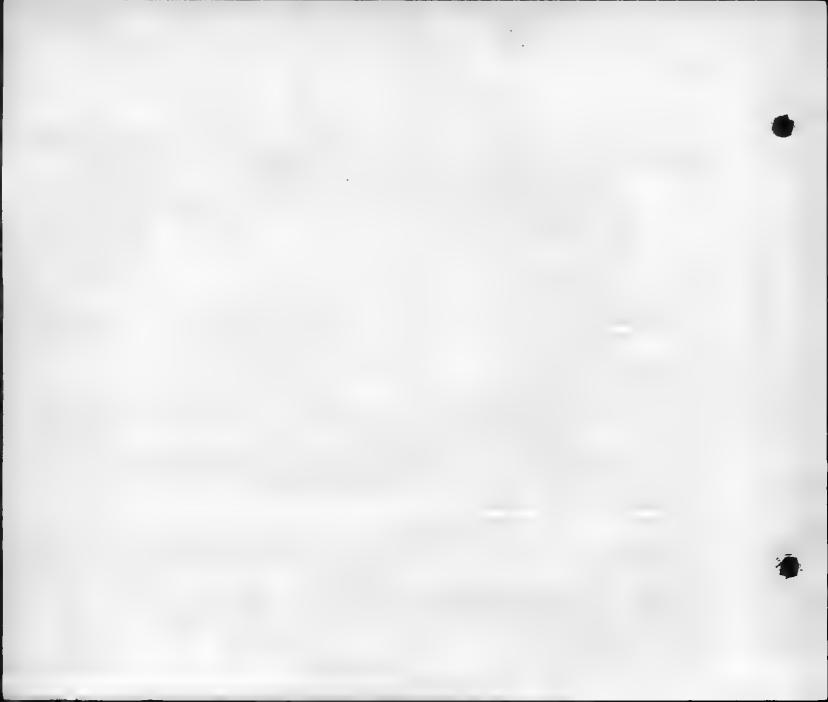
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REG. PIST.	THU.		

1.	PLACE OF DEATH o. COUNTY	Harford		MARYL	AND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Harford						
Г	b. CITY OR TOWN (If RURAL and give ne	Orest lown)	ts, write	c. LENGTH OF STAY II	чъ	c. CITY OR TOWN (IF	outside corporo					
L	Aberde			l		, A	berdeeb					_
L	d. NAME OF HOSPITA OR INSTITUTION	AL (If not in hospita), g	iva street	oddress)		d STREET ADDRESS					S RESID	ARM?
3.	NAME OF DECEASED (Type or print)	Thomas	•	Middle	C	losi	4. DATE OF DEATH	Mon	ith	Day	Ye	
5	SEX			ICO COL MICHES AND CONTROL		unther DATE OF BIRTH		Jan. AGE (In yeons	IF UNDER 1	VEADITE	19	
	male	White	WIDOWE	IED NEVER MARRIED		Mar.17. 187		lost birthdoy)			Ours	Min.
100			done 10b.	KIND OF BUSINESS OR	INDUST	TRY 11 SIRTHPLACE (Stole			12 CITIZ	EN OF V	VHAT C	OUNTRY
		ing life, even if retired Mer)	Owner		Harford	_			U.S.	Α	
13.	FATHER'S NAME					14. MOTHER'S MAIDEN I	MAME					
,,	inknown					unknown						
15.	WAS DECEASED EVER			SOCIAL SECURITY NO.	17. IN	FORMANT		Add	ress			
	no	If yes, give war or dates of s	etaice)	none	Mi	ss Bessie Gu	nther	Aber	deen.	Mary	lanç	1
			iuse peç lir	ne for (o), (b), and (c)]		,				INTERV.		
	PART 1, DEAT	TH WAS CAUSED 8Y: IMMEDIATE CAUSE (o	(~	· world		1 10	· .		ONSET AND DEATH		KAIII	
	420.1	DUE TO		- a	, ^	1 litere	C.	1 2	,	1	,	, 3 .
		Continues in Only, which										
	gove rise to immediate DUE 10 DUE 10											
	lying couse lost. (c) - ** ** ** ** ** ** ** ** ** ** ** ** *											
NOE	PART II. OTH	ER SIGNIFICANT CON	DITIONS	ONTRIBUTING TO DEAT	H BUT N	NOT RELATED TO THE TERM	INAL DISEASE (ONDITION GIV	EN IN PART	P	ERFORA	MED?
뎵	20 4 5 0 10 0 10 10 10 10		DOI - D.CO.							YE	s 🔲 🗆	но 🔲
CERTIFICATION	OR CONTRIBUTING	S UNDERLYING [] CAUSE OF DEATH MEDICAL EXAMINER)	205. DESC	-KIBE HOW INJURY OC	CURRED.	. (Enter nature of injury in	Port I or Port II	of item 18.)				
MEDICAL	20c. TIME OF INJURY Hour a. jr. p. m.	Month, Day, Yes	While	NJURY OCCURRED 2 Not while of work	Oe. PLA: focie	CE OF INJURY (Home, farm ory, street, office bldg., etc	20f. (City o	r town)	(Co	unty)		(Slote)
	21. I certify the	at I attended the	decease	ed from 1 tri	Seli	195 X, to J	L. 14.2	کر 19 کے	that I le	ist saw	the d	ecenses
	alive on T	an 22.	. 19			occurred at						
		1	1	111				et, city or town,)		E SIGNED
	ACTUAL SIGNATURE	one	sol	Vem	м	I.D. 114		EX A,	r A	1.		
	PHYSICIAN'S A	NDRE	11	Eiss 1	10		2 5-7	to 0,0	1663	1/	114	i.
220	BURIAL, CREMATION	N, 225. DATE THEREC	F	22c. NAME OF CEMET	ERY OR	CREMATORY	226. LOCATIO	N (City, town,	or county)		(Stote)	
L	REMOVAL (Specify) Burial	Jan. 25,	1959	Cokesbur	y Me	morial	Abing	don, Ha	rford.	Mar	ylan	id.
23,	FUNERAL DIRECTOR'S	11/1/1/	. (/	ADDRESS	lan 1	24a. REC*	D BY REGISTRA	R 24b. REGIS	STRAR'S SIGN	-		
Ľ	HTIZYA K	141/2000	Roll	Horngo	ion,	Maryland BATEJA	N 2 7 '59	C	v 2, 1	isaua		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



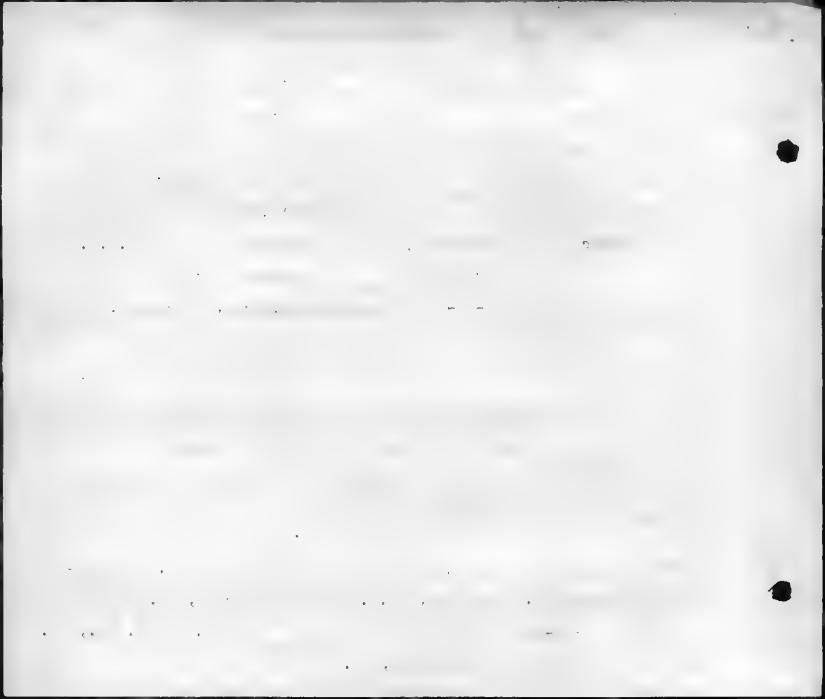
L		8 U	47							Reg. Dist	No.	
ī	PLACE OF DEATH					2 USUAL RESIL	DENCE (Wh	ere deceased l	ived If institution	n Residence	befare o	dmission)
	V. COUNT	Harfor	rd	MARY	LAND	0 SIAIE	Marv	land	b. COUNTY		Harf	ord
	b. CITY OR TOWN RURAL and give r	(If outside carporate limi learest town)	ts, write	c. LENGTH OF STAY	IN 15	c CITY OR 1			te limits, write RI	URAL and gi	ve nearest	town)
		rryman				X	Perr	yman				
	d. NAME OF HOSPI OR INSTITUTION	TAL (If no) in hospital, g	ive street	oddress)		d. STREET A	DDRESS				0	RESIDENCE ON A FARM? IS NO
)	NAME OF DECEASED	Fir	st	Middle		Los	1	4. DATE	Mon	th	Day	Year
	(Type or print)	HEN	RY			HAR	RIS	DEATH	Janua	rv	13	19 59
Š	SEX	6. COLOR OR RACE	7. MARE	RIED NEVER MARRI	ED 🗍	8. DATE OF BIRTI	Н	79	AGE (In yours	IF UNDER 1	YEAR IF	JNDER 24 HRS.
	Malo	Colored	WIDOWI	ED DIVORCE	D 🔲		ober	1881	77 yrs	Manths C	Days Ho	ours Min
	On USUAL OCCUPATE	ON (Give kind of work or rking life, even if retired	done 10b.	KIND OF BUSINESS C	R INDUS	TRY 11 BIRTHPL	ACE (State of	ar foreign cau	ntry)	12. CITIZ	EN OF W	HAT COUNTRY
		oren		Dishwashi	no		Maryl	and.		U.	S.A.	
ì	3. FATHER'S NAME				-	14. MOTHER'S						
				(Unknown))	1	Eliza	beth	Harr is			
ĺ	S. WAS DECEASED EV	ER IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO	17. 11	NFORMANT			Addr	ess		
	No		21	.8-07-7310		ry Hol	lings	worth	, Per	rymar	, Ms	ryland
		ATH [Enter only one co	use per lie	ne for (0), (b), and (c).]						INTERVA	AND DEATH
	PART I. DE.	ATH WAS CAUSED BY: IMMEDIATE CAUSE (o	<u>, C</u>	ere bral	Th	rombo	5/5				014321	NITO DEATH
	L'	DUE TO										
	Conditions, if		,									
	gave rise la cause (a), stoting	immediate (1	1		1		, 1	1)			
	tying cause lost.) (c	1449	pertensive	Ar	terio Sc	lenot	ic Hea	rt dis	ease		
3	PART II. OT	HER SIGNIFICANT CON	PENOITIO	CONTRIBUTING TO DE	ATH BUT	NOT RELATED TO	THE TERMIN	NAL DISEASE (CONDITION GIV	EN IN PART	1(o) 19. W	AS AUTOPSY
	3											ERFORMED?
Charles and a second	PART II. OT	AS UNDERLYING G CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY O	CCURRE). (Enter nature o	f injury in P	ort t or Part t	of item 18.)			
2	20c. TIME OF INJU		or 20d. II While	NJURY OCCURRED Not while		CE OF INJURY (I fory, street, office			r town)	{Co	wnly)	(State)
1	p. m.	19		k at work								
	21. I certify t	hat I attended the	deceas	ed fram Dec.	2	2 . 19 57	, ta_J	an. 1	2., 19.59	.that I is	ist saw	the decease
	alive on	January 12			death	accurred at	12:20	amfram	the causes a	nd on the	e date s	tated above
		. 1	7	71 1					et, city or town,		o date s	DATE SIGNE
	ACTUAL SIGNATURE	Lorge J.	1	tanslary		5	69 Re	volut	ion St		1-1	1-59
	3101041042	0	7	1	-	W.D						±
	PHYSICIAN'S NAME (Type)	George T	- St	ansbur v.	M.	D. H	avre	de Gr	ace. M	d.		
2	20. BURIAL, CREMATIC			22c. NAME OF CEM					ON (City, town, o			(State)
	REMOVAL (Specify	1-16-5		Ashury		netery			ey, Ba			
2	3. FONERAL DIRECTO			ABPHESTI		uneral	285 8653	BY REGISTRA				
	John H.	Jan und		Aberde			DATE ()					
4	111-111-	Vanna		ADOT U	447	-14/17 6	MAIL CHT	N 1 9 '59	(1.	lung 9.	Same.	

may be recoved by the hospital or attending physician.

TO FUNER SIRILIES. After this survisionable has been signed by the attending physician and completely filled the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror prior to burial, cremation, or remaval, and in any event within 72 hours after death. VS A15 (4) 15M 9/5\$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 how

gs ofter death: Page 4



FUR STATE HEALTH DEPT MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00683

6.MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No

0	1, 1	PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institution Regidence before admission)
	ſ	MARYLAND O. STATE WAS B COUNTY HOUSE
	Ь	CITY OR TOWN (If autside corporate april and a RURAL and give nearest lown)
		Have de brace - 1 hour /! Have I Grace
Ŧ	d	I. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE
		Harford newil Hartet Lewis Love VES PONDE
		NAME OF DECEASED A First Middle Lost 4. DATE Month Day Year -
		MINNIE LOCKA HOTTISON DEATH January 17 1959
	5. \$	The state of the s
		emale WIDOWED B DIVORCED 1 JULY 29 1874 8 4 yes Months Days Hours Min
	10o	USUAL OCCUPATION (Give kind at work done 10b KIND OF BUSINESS OR INDUSTRY 1) BIRTHPLACE (State or foreign country) 12 CIT ZEN OF WHAT COUNTRY?
		HOUSE WIFE HOME NEB. U.S.A.
	13.	FATHER'S NAME 14. MOTHER'S MAIDEN NAME
		UNKIVE VVIV BRIGAS UNKIVE VIN
	15, (Yes.	WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address
		- The MINNIE SIMPERS ELKTON, MD.
į		18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPhixid due 1800/180
~		9210 DUETO BASTS-NCT,ON
		Canditions, if any, which (b)
		(a), stating the underlying DUE TO
	_	couse last. (c)
2	Õ	PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?
-	Ž	AE2 WO
	CERTIFICA	200. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18.) CAUSE OF DEATH. Charles on bases Charles on ba
	Š	The state of the later of the state of the s
y.	MEDIC	Hour A 1 1 - 4 - A - A - A - A - A - A - A - A - A
	*	pm 1 192 / ot work of work & Home Haved true Harfor Ma
		21. I certify that I taak charge of the remains described above, held an Autapsy [], Inspection [], Inquiry [], and in my
		apinion death resulted from: Natural causes Accident Suicide, Homicide, Undetermined manner
		ACTUAL DAY ALC POLICE SIGNED
		SIGNATURE AND CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER
		EXAMINER'S GETOID EPOIMES 1-18-5-9
	22a	BURIAL CREMATION, 226 DATE THEREOF 22C. NAME OF CEMETERY OR CREMATORY 22d. ECCATION (City, town, or county) (Slove)
	4	BURIAL JAN. 20,1951 ELKTON (EM. ELKTON, MD
	23.	FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240, REC'D BY REGISTRAR'S SIGNATURE
	1.	Madrey Milehell HAVRE DE GRACE, MD DATEAN 20158 Outling & Hom

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only dealy is necessary, please execute the control of the word "pending" in pending them. 18. Give Pages 1, 2, and 3 to the funeral form flags a should be it carded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained four files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages, 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, ar removal, and in any event within 72 hours after death VS A15ME 5M 2/57



VII A15 (4) 15M 9/55

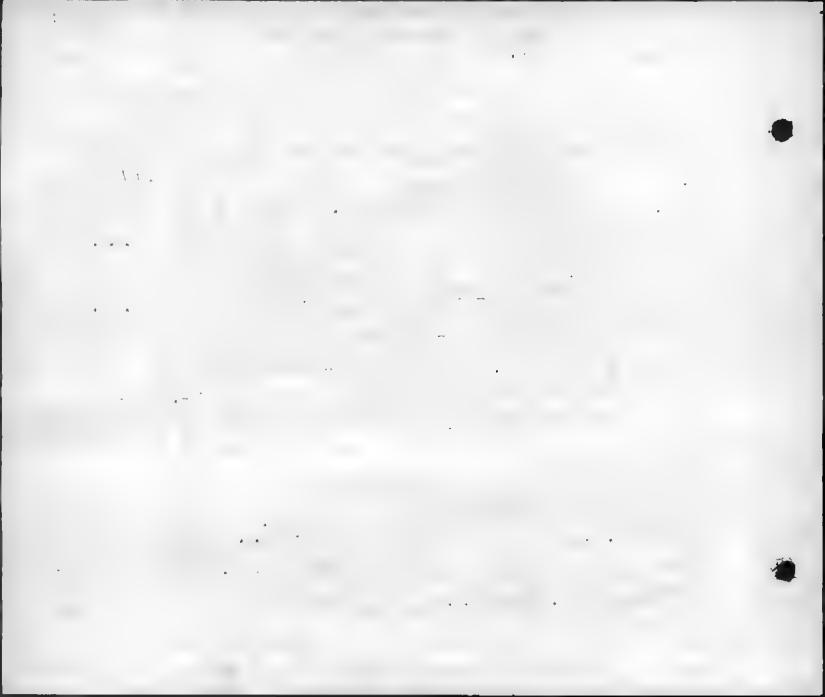
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00684

_	010 CERTIFIC	AIL OF BLAIR	Reg. Dist. No.
3.	PLACE OF DEATH COUNTY HARFORD MARYLAND	2. USUAL RESIDENCE (Where decease o STATE MAP 4/And	ed lived. (f institution: Res'dence before admission) b. COUNTY CEC. /
	b. CITY OR TOWN (If authide corporate limits, write RURAL and give nearest town)	CITY OF TOWN of outside cor	orate limits, write RURAL and give nearest town)
-	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION HARFORD MEMORIAL HOSP,	d. STREET ADDRESS & 3	e. IS RESIDENCE ON A FARM? YES NO NO
	NAME OF DECEASED (Type or print) NEH E EVELVA	Lost 4. DATE OF DEAT	Month Day Year
J	SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED TO	110117	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
16.		JSTRY 11. BIRTHPLACE (Stole or foreign	country) 12 CITIZEN OF WHAT COUNTRY?
13.	FATHER'S NAME TO THE TOTAL CONDINS	14 MOTHER'S MAIDEN NAME	2 U.S.FF.
15.	no or unknown) (if yes, give war or dates of service)	INFORMANT AND MILE	Address Offerd Pa
-	18. CAUSE OF DEATH {Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY:	(a. in leve a	S Jugas & Tom ONSET AND DEATH &
	Canditians, if any, which gove rise to immediate couse (a), the property of the couse (b) ACC in process of the property of the process of th	circuit of.	Light of die Han Dig
CERTIFICATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERMINAL DISEA	SE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY PERFORMED? YES NO N
	206 ACCIDENT WAS UNDERLYING [] 206 DESCRIBE HOW INJURY OCCURRY (IF EITHER, NOTIFY MEDICAL EXAMINER)	ED (Enter nature of injury in Part for Pa	rt (I of item 1B.)
MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. P. Hour e. m. 19 While Not white of work 1 of york 1	LACE OF INJURY (Home, form, 20f (Ci octory, street, affice bidg., atc.)	y ar town) (County) (State)
	21. I certify that I attended the deceased from DCC, DC alive an 12 3 76 5 19 5 7 and that death	19.18. to 1/2 h accurred at 4,35 M. fro	m the causes and on the date stated abaye.
	ACTUAL SIGNATURE (ELL.) TE (ELL.)		Street, city or town, store) DATE SIGNER
	PHYSICIAN'S FIELD PRINT COMME (Type) FIELD PRINT COMME	is Harre- cl	Epace had 10 An
L	PEURIAL GREMATION, 226, DATE THEREOF 22c HAME OF CEMETERY COMMONTAL (Specify)	OR CREMATORY 228 LOC	Dot Defect Ma
23.	FUNERAL DIRECTOR'S SIGNATURE ADDRESS CALL	240 REC'D BY REGI	



1	*				MARYL	AND	STATE D	DEPARTM	LENT OF	HEALTH	f—BAI	LTIMORE	, 18	11	068	2=
2.E	ان				71	.0	Cl	ERTIFIC.	ATE OF	DEATH	1		Reg.	Dist. No))
director	EA '		1 8	LACE OF DEATH	Harford			MARYLAND	2 USUAL R o. STATE New	York C	ity	ed lived If inst b. COU		dence befo	re admiss	ion}
inneroi Id be	. madest		ŀ	RURAL and give n	If outside corporate limit recreat town Pel Air	s, write		r stay in the	c. CITY C	R TOWN (If c	outside corp	Orote limits, wri	le RURAL o	nd give ne	arest town)
d 2 shot	,	' 1	F	NAME OF HOSPI OR INSTITUTION INSTITUTION	TAL (If not in hospitol, gi	Home	address}		d. STREE	T ADDRESS					e. IS RES ON A YES	IDENCE FARM? NO X
es i an				IAME OF DECEASED Type or print)	MARIE			Middle		lost OZA	4. DATE OF DEATH	1	Month Jan.	e / De	*	Year 159
60			5 . 5	_	6 COLOR OR RACE				8. DATE OF B		A -	9. AGE (In ye	ars IF UNE	DER LYEAR	Hours	R 24 HRS. Min.
ers.			10-	Fem.	White	WIDOWE	444.3	IVORCED [Sept.	11, 18	87	1 7 -	yrs		<u> </u>	
on pap		- L	_		ON (Give kind of work diking life, even if retired)	one IVb. I	KIND OF BUSI	NESS OR INDU				country)		CITIZEN C		COUNTRY
2000		- 1	13.	ATHER'S NAME	ah Hana				14. MOTHE	R'S MAIDEN N						
SHE			15.		THE HOZE	FS2 114 G	SOCIAL SECUE	HITY NO. 117	INFORMANT	Stetka	LOAS		Address		<u>.</u>	
77.0	7) [(Yes	No No	(If yes, give wor or dates of se	man) OR:	2-22-57	796	Frank I	Benisek			elcam	p, Md	•	
					ATH [Enter only one col		e for (o), (b), o	ond (c).] -hyposta	atic					INT ON:	ERVAL BE	TWEEN DEATH
vent				4431	ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO											
) AU				Conditions, if	iny, which) (b)	Chr.	hypert	ensive	cardio	-vascul	ar di	sease			??	
o ui pa				gove rise to i couse (a), stating lying couse lost.	the <u>under-</u> DUE TO							aresisi				
povoi		3	CATION	PART II. OT	HER SIGNIFICANT CONT		Mellit		NOT RELATED	TO THE TERMI	NAL DISEA	SE CONDITION	GIVEN IN F	PART 1(o) 1	PERFO	RMED?
or ren			CERTIFI	70a. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIFI	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER	20b. DESC	RIBE HOW IN	JURY OCCURRI	D. (Enler natur	e of injury in I	Part I or Pa	et II of item 18.				
emotion			MEDICAL	20c. TIME OF INJUI Hour a. jr. p. m.	RY Month, Day, Yea 19	While	Not white	6.	ACE OF INJUR	Y (Home, form fice bldg., etc.	20f. (Cit	ly or town)		(County)		(Stote)
				21. I certify t	hat I attended the	decease										
buri				alive on_Lar	1, 1959	_, 12	, and	d that deatl	occurred			m the cause		the da		
or ior				ACTUAL SIGNATURE	illand	Pa	Die	lson	M.D. FOI			Street, city or to	wn, stalej			TE SIGNE
stror r		4		PHYSICIAN'S NAME (Type)	Bland P. Hu	dson.	M.D.		F	rest_H	<u> </u>	Md				
he real	n i		220	REMOVAL Specify	16 11 1	959	(1)	CE 12 17 in	R CREMATORY		22d. LQC/	ATION (City, toward the			(Stote	
)			- /	Sarf B	S SIGNATURE	Fice	ADDRESS		92	24a. REC'I	D BY REGIS	STRAR 245. R	EGISTRAR'S	SIGNATU	RE	
		t		1306-1	Detain Ad	-1 /2	detis	well -	6. 5000	/ JA	(% a	5		1 11 ,00	espis.	



may be retained to the hospital or attending physician.

TO FUNERAL DIVACIOR: After this certificate has been signed by the ottending physician and campletely filled in by funeral directors page 3 should be detached far use as the burial-transit permit. Then please remove carbon, papers. Pages 1 and 2 should be fi ed with the registrar prior to burial, cremation, ar removal, and in any event within 72 haurs, offer death. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

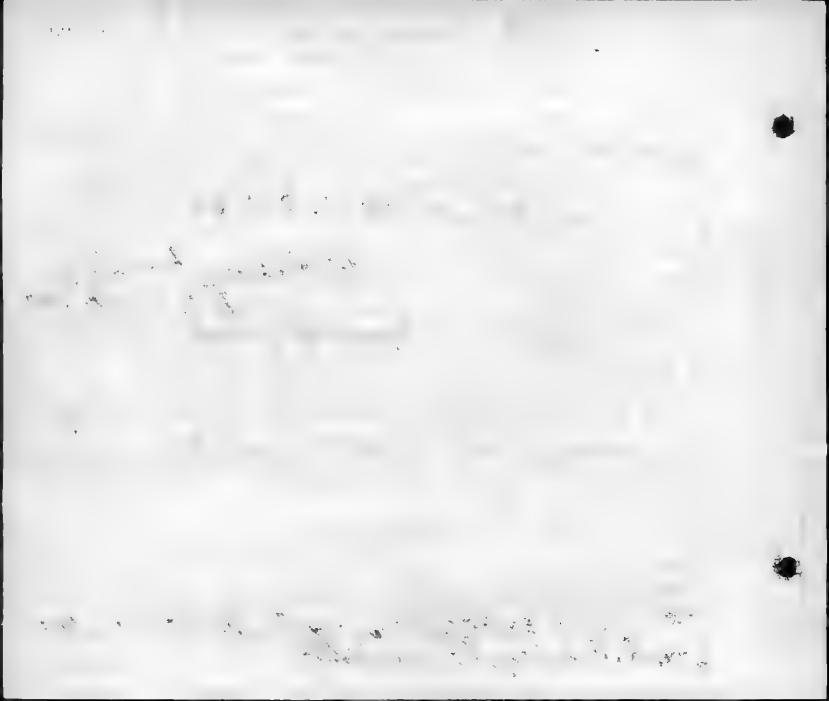
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 679 **CERTIFICATE OF DEATH**

00686

Reg. Dist. No.

: 1		Key, Dist, Ito.
)	1. PLACE OF DEATH O. COUNTY HARFORM MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o. STATE ARFORD
	B CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) HALLEC OL GRACE 18 LVs	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION HOREOR MEMBERAL HESPITAL	d STREET ADDRESS o. IS RESIDENCE ON A FARM? YES NO
	3. NAME OF DECEASED (Type or print) Clement Morten H	Utchinson A. DATE Month Doy Year Of DEATH CANUORY 19 19 59
	5. SEX Male 6. COLOR OR RACE 7. MARRIED DIVORCED DIVORCED	B DATE OF BIRTH BY 1 1898 P. AGE On years If UNDER 1 YEAR IF UNDER 24 HRS 1031 Friday) Months Days Hours Min
	100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRIES OF STREET OF BUSINESS OF INDUSTRIES OF STREET OF STREET OF BUSINESS OF INDUSTRIES OF BUSINESS OF INDUSTRIES OF BUSINESS OF INDUSTRIES OF BUSINESS OF INDUSTRIES OF BUSINESS OF BU	11 BIRTHPUCE (Stole or foreign country) 12 CITIZEN OF WHAT COUNTRY?
	MORTON CLEMENT HUTCHINSON, SA	Kathelen E Honeley
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY. NO. 17. II (Ye) no or unknown) II yee, give wor or doller in retrice)	NEORMANT With the there of Dorlington Me
	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)	Infloritie leuhama Interval Between ONSET AND DEATH
	DUE TO Conditions, if any, which) (b)	
	gove rise to immediate couse (a), stating the under-lying couse lost.	
1	ICARIC	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS ALTOPSY PERFORMED? YES P NO
		D. (Enter nature of injury in Port I or Port II of item 18.)
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour o. m. p. m. 19 While Not while of work of work	ACE OF INJURY (Home, form, 20f. (City or town) (County) (State) clory, street, office bidg., etc.)
	21. I certify that I attended the deceased from may alive on 19 19 19 19 19 19 19	1948, to 19, 1949, that I last saw the deceased accurred at 1153 AM, from the causes and an the date stated above.
a	ACTUAL (), DO PI DO	MD. Darlington Ind 1/19/19
i i	PHYSICIAN'S Dudley Phillips	DARIOUSTON, Ind
	229 DATE THEREOF 22. NAME OF CEMETERY OF COMMENTER OF CEMETERY OF COMMENTS OF	may Cin Baltimory And,
	23 FUNERAY DIRECTOR SIGNATURE Bailen Harling	JAN 2 6 159 C +2 of & Kegara

TO HOSPITAL OR VS A15 (4) 15M 9/55



may be retain. TO FUNERAL DINACTOR: After this certificate has been signed by the attending physician and completely filled in by uneral director, page 3 shauld be detached for use as the burial-transit permit. Then please remays, carbon papers. Pages 1 and 2 should be filed with the regist prior to burial, cremation, memory, and in any event within 72, hours after death. TTENDING PHYSICIAN: The flaw requires that the death certificate be executed within 24 hours after death: Page TO HOSPITAL OF

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00687 Barry Potes All

,	711 CERTIFICA	TE OF DEATH	Reg. Dist. No.
	1. PLACE OF DEATH O. COUNTY Haryland MARYLAND	o. STATE Marylund	b. COUNTY Hurfard
	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) B. C. LENGTH OF STAY IN 16 RURAL and give nearest town) G. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	X Bel aus	e timits, write RURAL and give nearest town)
	R.D. Bull - air	Rock Spring	Month Day Year
	(Type or print) CLARENCE, A.	ACKSON DEATH	AGE (In years IF UNDER I YEAR IF UNDER 24 HRS
	male negro widowed DIVORCED []	Jug 25, 1900	fost birthdoy) Months Doys Hours Min
	100. USUAL OCCUPATION (Give kind of work done of the lotter of the state of the lotter	100 O . Ol. Se	Caryland ZL S, A
	13. FATHER'S NAME HENS, G. C. Garbanil	14 MOTHER'S MAIDEN NAME	agino
	15 WAS DECEASED EVER IN U SARMED FORCES? 16. SOCIAL SECURITY NO. 17 IN (May no or unknown) Was NO or unknown) Was Was U was F 218-30-6207 M	Stella E. Jacks	m Bel-der, New
	PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) [12000 - 2000	6 feeter	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which) DUE TO DUE TO DUE TO	Let .	2 dieses
	gove rise to immediate couse (a), stoling the under lying couse lost. DUE TO (c)	Maignet / 4/2	olenoem syn 6 charge
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT		ONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO
	200 ACCIDENT WAS UNDERLYING [] 206 DESCRIBE HOW INJURY OCCURRED OF CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)). (Enter noture of injury in Port I or Part II	of item 18.)
	20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED for Hour o. m. 19 While of work ol work	CE OF INJURY (Home, form, 20f. (City or lory, street, office bldg., etc.)	town) (County) (State)
			that I last saw the deceased he causes and an the date stated above.
	SIGNATURE - HI Staller	AD. #2/7 Menally y	Part Signed
/	PHYSICIAN'S A P. S. DWELL		<i>}</i>
	220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAMS OF CEMETERY OF BURIAL SPORTLY 1/12/59 Jubernacle	Ceretery Been	N (City, lown, or county) (State)
	23 FUNERA. DIRECTOR'S SIGNATURE Eliner E. Bullock Haved 91	Lace, Mcd DATEJAN 1 3 '59	R 24b. REGISTRAR'S SIGNATURE



4		MARYLAND STA	ATE DEPARTM	ENT OF HEALTH—BA	LTIMORE, 18	nacco
		680	CERTIFICA	ATE OF DEATH	Reg. Di	00688
I director.	1. (LACE OF DEATH HARFORD	MARYLAND	2. USUAL RESIDENCE (Where decease o STATE	b. COUNTY	ice before admission)
Internal Int	1	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fawn)	HR.	e. CITY OR TOWN (If outside corp	porote limits, write RURAL and	give nearest lawn)
2 P	Ŀ	NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION Memorial	Hospital	d. STREET ADDRESS		o. IS RESIDENCE ON A FARM? YES NO
filled in b		AME OF ECEASED SUSAN SUSAN	ANN	KIGORE JEAT	*f*	Doy Year 21 1957
pletely in Pog	5 5	Female W WIDOWED []	DIVORCED 🔲	1. DATE OF BIRTH May 25, 1958	last birthdoy) Months	1 YEAR IF UNDER 24 HRS
ond com		USUAL OCCUPATION (Give kind of work done 10b. KIND during most of working life, even if retired)	OF BUSINESS OR INDU	md	country) f2. C11	USA
5 5 5 4	L	OSCAR S. Kil	1 gore	14 MOTHER'S MAIDEN NAME PUOREL	, u	iley
ing physici re remove 72 hours		VAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCI/ no. or unknown) (11 yes, give war or dates of service)		SCAR KILGORE	DELTA, PA	\.
ottend ot within		IB. CAUSE OF DEATH [Enter only one couse per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	(0). (b) and (c).]	2		INTERVAL BETWEEN ONSET AND DEATH
l by the		57/. O DUE TO Conditions, if ony, which) (b)				
ion. in signed in o		gove rise to immediate couse (a), stating the under-tying couse lost.				
physici physici nas been rial-tran noval, a	CERTIFICATION	Part II. OTHER SIGNIFICANT CONDITIONS CONTE				T I(o) 19. WAS AUTOPSY PERFORMED? YES NO T
fending ifficate the bu	4	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	HOW INJURY OCCURRE	D. (Enter noture of injury in Port I or Po	ort It of item 18)	
ol or of this cert r use os remotion	MEDICAL		OCCURRED 20e PL. Not while of work	ACE OF INJURY (Home, farm, 20f. (Citary, street, office bldg., etc.)	ity or lown) (Countyj (Stote)
e hospil		21. I certify that I attended the deceased frailine an Jan 1959	VIII	accurred at 7. 4 MM, fro		last saw the deceased
d be deto		ACTUAL SIGNATURE PAR BO	ethil	ADDRESS (Street, city or town, state)	D. Van 21/9
A Prop		PHYSICIAN'S ROBEYT B	ARTHEL		/	J
may be may be poge 3 all the regist	L	PENOVAL (Specify) 1-23-59	NAME OF CEMETERY O	_	ATION (City, town, or county)	ak Co., Pr.
VS A15 (4) 15M 9/55	23	Later It. Italia I	DELTA P	240. REC'D BY REGI DATEJAN 2 6 "		GNATURE Frank
	1					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 681 **CERTIFICATE OF DEATH** Reg. Dist. No I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Revidence before admission) o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If butside corporate limits, write c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest fown) RURAL and give nearest fawn) d. NAME OF HOSPITAL III not in hospital, give street address d. STREET ADDRESS OR INSTITUTION þ NAME OF 4. DATE Manth DECEASED. (Type or print) DEATH 9. AGE In years 5. SEX 7. MARRIED T NEVER MARRIED 8 DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HGS 6 COLOR OR RACE Months WIDOWED. A DIVORCED [7] 10a USUAL OCCUPATION (Give kind of work dane) 10b, KIND OF BUSINESS OR INDUSTRY M. BIRTHPLACE ISlate or foreign country) death, during most of working life; even if retired) 122/20 carbon 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME hours 15. WAS DECEASED EVER IN U.S. ARMED FORCES?" 16. SOCIAL SECURITY NO. 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ERITONITIS **DUE TO** BLADDER - PELVIE Canditians, if ony, which gave rise to immediate **DUE TO** PROSTATIC HYPERPLASIA cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY [Hame, farm, 20f. (City or town) factory, street, office bldg., etc.) Hour o. m. While Not while at work a of work

FUNER 0

NAME (Type) 220 BUR AL CREMATION DATE THEREOF REMOVAL (Specify)

SIGNATURE PHYSICIAN'S

21. I certify that I attended the deceased fram.

OR CREMATORY

and that death accurred at_____M, fram the causes and an the date stated above.

ADDRESS (Street, city or town, state)

22d LOCATION (City, town, or county)

246 REGISTRAR'S SIGNATURE

(County)

e. IS RESIDENCE

Day

Days

ON A FARM? YES NO X

Year

19 -

Hours

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES NO

> > (Stote)

DATE SIGNED

(State)

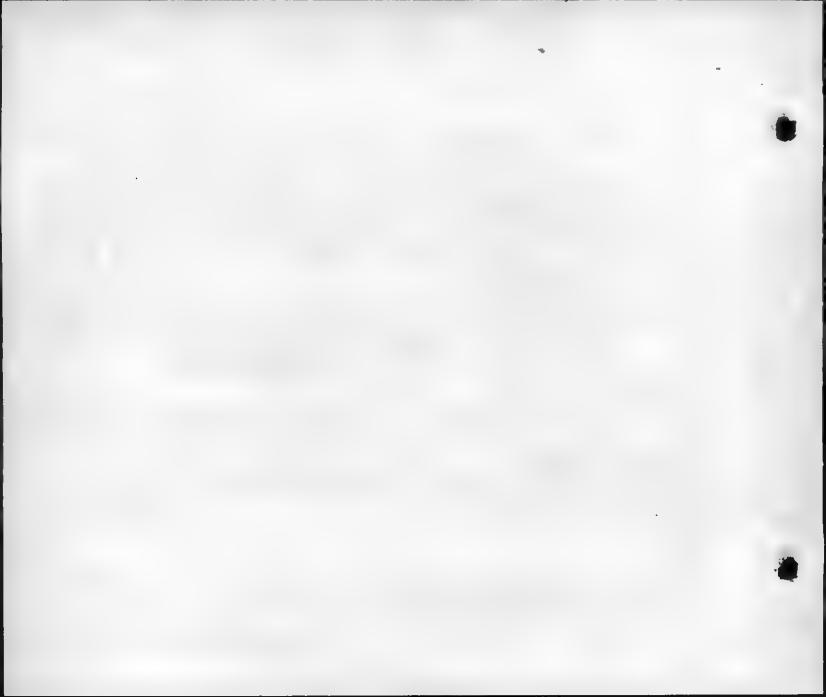
12. CITIZEN OF WHAT COUNTRY?

arthur S. Thank

159, ta 1 = 13, 1959, that I last saw the deceased



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 opesa 682 CERTIFICATE OF DEATH Rea. Dist. Na 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lifed. If institution. Residence before admission) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside carporate limits, write c. LENGTH OF STAYAN IN c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) RURAL and give negrest lown) O open d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES IN NO IS 2 NAME OF 4. DATE Middle Day Year DECEASED OF (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (b) years lost by theory) Months Davs Hours WIDOWED IZI DIVORCED 4114 papers. 10g USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY) BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRYS during most of working life, even if retired) pua pou 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME COL physician remove 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (I) yes, give wor or dotes of service) 18. CAUSE OF DEATH [Enter only one cause per line for fo), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Ë. any Conditions, if any, which gned gave rise to immediate DUE TO cause (a), stating the underlying cause last, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY **burial-tr** PERFORMED? YES NO Z 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, form, | 20f. (City or town) 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) Hour a. n. While Not while at work at work 21. I certify that I attended the deceased from 19_5_Z, that I last saw the deceased #30M, from the causes and on the date stated above. and that death occurred at ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE AL D PHYSICIAN'S NAME (Type FUNE 220. BUR.AL, CREMATION, 226. DATE THEREO! 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) pode EMOVAL (Specify 0 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 1SM 9/55



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00691

. IS RESIDENCE ON A FARM?

YES 🗍 NO 🔀

Yeor

19

Reg. Dist. No.

IRTH /	9. AGE (In years lost birthday)	IF UNDER 1	YEAR IF UN	IDER 24 HRS
91888	70 yrs	Months D	Pays Hou	rs Min
HPLACE (State or foreign	country)	12. CITIZ	EN OF WH	AT COUNTRY?
10		4.	S.A.	
R'S MAIDEN NAME				
4 VAME CU	ANTLE	R		
LIEF. PYLE	HAVRIE DE	GRACE	Moit	Det/
				BETWEEN O DEATH
monto	zes		20	120
Censo a	Prist 31	,	20	les
TO THE TERMINAL DISEA		'EN IN PART I		S AUTOPSY FORMPOT
e af injury in Port I or Po	ort II of item 18.)			
(Y (Home, form, 20f (Ci ffice bldg., etc.)	ly or town)	(Co	unly)	(State)
5410 1/30	19.5	Z,that I la	st saw th	e deceased
at Ja Sol M. fot	m the causes o	ind on the	date st	ated above.
# ADDRESS	Street, city ar Iown,	Hate) Hus	40.0.	DATE SIGNED
015.6N	om the causes of Street, city ar lown,	L(A	West.	1/31/55
		10-	mo.	/ /
1 201105	ATION (City, town, i			
. //	THE DE	TPACE	= 1s	tote) (O
240. REC'D BY REGI	STRAR 246 REGIS	STRAR'S SIGN	NATURE	
· DATE FR 3	0	2 f		
* 9 2		1 13	pularys	



FOR STARE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00692

719 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6.4.6					ig. Dist. No.
I. PLACE OF DEATH			2. USUAL RESIDENCE (W	here deceased lived. If institution:	Pesidence before admission)
Har	ford	MARYLAND	o. STATE Maryl	and b. COUNTY	Harford
b. CITY OR TOWN (If outside corporate and give nearest fown)	e fimils, wills RURAL C.	LENGTH OF STAY IN 16	C CITY OR TOWN (IF	outside corporate limits, write RURA	AL and give neorest town)
Jop	08.		×	Joppa	
d. NAME OF HOSPITAL OR INSTIT		l, give street oddress)	d. STREET ADDRESS		e 15 RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) Willi	First	Middle J. H.	Lyons	4. DATE Month OF DEATH January	28, 1959
5. SEX 6 COLOR C	OR RACE 7 MARRIED	NEVER MARRIED B	DATE OF BIRTH		NDER TYEAR IF UNDER 24 HES
Male whi	te WIDOWED	DIVORCED	Nov.21.1931	Tost birthday) yrs. Mor	oths Days Hours Min
10a USUAL OCCUPATION (Give kind during most of working life, even if	of work done 10b KIND retired)	OF BUSINESS OR INDUST	RY 11 BIRTHPLACE (Stole o	ar foreign country)	2. CITIZEN OF WHAT COUNTRY?
Metal Worker	Auto	omobile	Maryland		U.S.A.,
Jess A . 15 WAS DECEASED EVER IN U. 5 A . 16 WAS DECEASED I SET IN U. 5 A . 17 WAS DECEASED I SET IN U. 5 A . 18 WAS		IAL SECURITY NO 17, W	Elizabeth	Porter Address	
ves 1952		-28-9181 Mr	s. Elizabeth	Anderson, Joppa	.Marvland
18 CAUSE OF DEATH [Enter on	ly one couse per line for (7	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUS	SED BY: CAUSE (0) Coron	ary Artery So	clerosis with	Coronary	Onth sho bean
1 1				scending Artery	
Conditions, if ony, which	[p]	DOSTO OT TOT	o Mitolifol Do	accurating and north	
gave rise to immediate couse (DUE TO				
couse lost.	(c)			y 50 Services or war	
PART II, OTHER SIGNIFICATION OF THE PRIMARY OF CONTRIBUTING IN CAUSE OF DEATH.	ANT CONDITIONS CONTR	BUTING TO DEATH BUT N	OT RELATED TO THE TERMIN	HALDISEASE CONDITION GIVEN IN	PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
	206 DESCRIBE HO	OW INJURY OCCUPRED. (E.	nter noture of injury in Fort	For Port II of item 18.)	- d
9		I I I	E OF INJURY (Home, form, ery, street, office bldg., etc.)	20f. (City or town)	(County) (Stole)
Hour e.m.	19 of work		ry, silesi, onice biog., etc.;		
21 1 certify that I tack	charge of the rem	ains described abov	ve, held an Autapsy	Z, Inspection , In	quiry , and in my
opinion death resulted for	ram. Natural cau	ses 🔂 Accident [, Suicide , H	lamicide 🔲, Undetermin	ned manner
ACTUAL SIGNATURE	usell &	Fisher	M D CHIEF MEDICAL EXA	Janua	ery 29, 1959
EXAMINER'S NAME (Type) RUSS	ell S. Fishe	r. M.D.	DEPUTY MEDICAL EX	XAMINER [
220 BURIAL, CREMAT ON, 226 DAT REMOVAL (Specify)	TE THEREOF 22c	NAME OF CEMETERY OR Prinity Luthe		72d LOCATION (City, town, or eou Joppa, Harford,	
23. FUNERAL D RECTOR'S SIGNATOR		ADDRESS BUTTLE		BY REGISTRAR 246, REGISTRAR	
Howay II	lite mun DAT	bingdon, Maryl	and.	2 '59 ~ ~	8 11 11 A

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necess execute the case, writing the word "pending" in pendil shem. 18. Give Pages 1, 2, and 3 to the funeral 4 should be monded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transis permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in the sector within 72 hours after death. VS A15ME 5M 2/57

X Nov.21,1931

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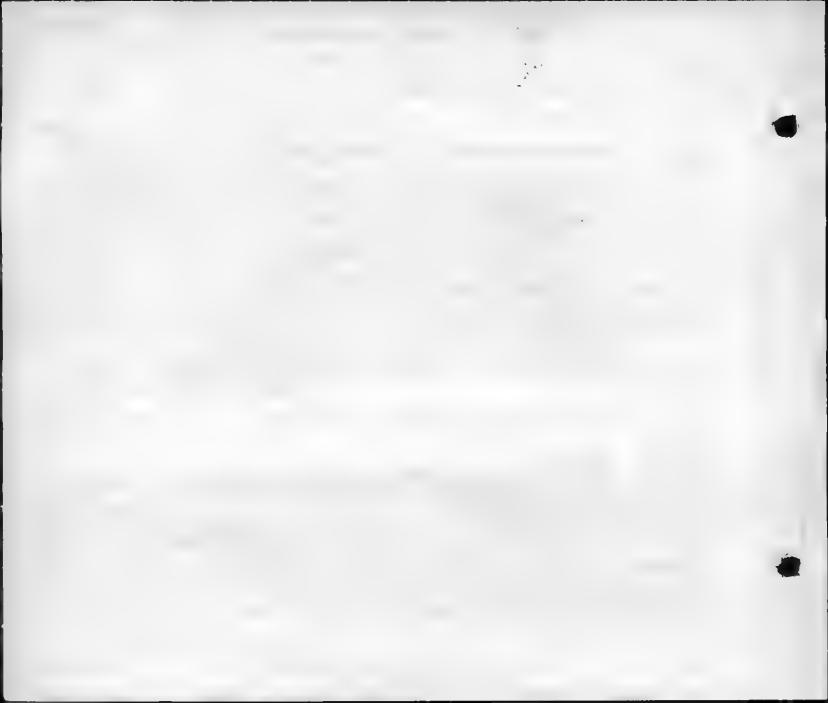
. I r

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00693

CERTIFICATE OF DEATH Reg. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) COUNTY **b.** COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest towp) d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO [7 NAME OF Middle 4. DATE Month DECEASED OF DEATH Januare (Type or print) 19 4 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED P B DATE OF BIRTH AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS aLC DIVORCED [WIDOWED [7] 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 during most of working life, even if retired) BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13 FATHER'S NAME ELLSWORTH 17 INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO Address 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) CEREBRAL DUE TO Conditions, if ony, which gave rise to immediate **DUE TO** OVERWHELMING VIHAL INFECTION (? PREUMONI) couse (a), stoting the underlying couse lost. PAIN II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES P NO 200. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port 1 or Port 11 of Item 18.) MEDICAL 20c. TIME OF INJURY Month, 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, Doy, Year 20f (City or town) (Stole) (County) foctory, street, office bldg , etc.) Hour a.m. While Not while el work of work 21. I certify that I attended the deceased from JAN. 14, 1959, ta JAN: 14, 19 That I last saw the deceased , and that death accurred at 11-2013M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED practic dans ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220 BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City (Stole) TEMOVAL (Specify) RIDGE MURIA 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE · hur S. Thais

15M 9/55



VS A15 (4) 15M 10/57

MARYLAND	STATE DEPARTMENT	OF HEALTH—BALTIMORE,	1
685	CERTIFICATE	OF DEATH	

CERTIFICATE OF DEATH

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	d NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION d. STREET ADDRESS 3 Chesaleus Duin	e. IS RESIDENCE ON A FARM? YES NO 5
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	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). PUMORIHERY ENERGY	INTERVAL BETWEEN ONSET AND DEATH
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MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Positive of work 19	ounty] (State)
	21. I certify that I attended the deceased from DEC 8, 1958, to VAL 17, 1957, that I lo	ist saw the deceased
	alive on JASLII, and that death accurred at 724AM, from the causes and on the	date stated above.
	SIGNATURE . A FORD MD. 200 A. UNION ANT.	1/2/159
	PHYSICIAN'S / P KOSS HAURE DE GIZACE	Mn
22	REMOVAL (Specify) / 10/54 22c. NAME OF CEMETERY OR CREMATORY 27d. LOCATION (City, town, or county)	M/3'0'4)
23	ADDRESS 240. REC'D BY REGISTRAR 246 REGISTRAR'S SIGN	VATURE
	DATE JAMES	1.4



1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18					
FOR STATE		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.					
HEALTH DEPT.		PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
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\$ 7 m m m	13.	FATHER'S NAME 14. MOTHER'S MAIDEN NAME					
E 85 8 1		AVIS Wandon Dowell					
Pe a ge	15.	WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address					
Signal F		, no, or unknown)					
H N N N N N N N N N N N N N N N N N N N	-	no none Avis W. Morrison, Aberdeen R.D., Md.					
d garage		18. CAUSE OF DEATH. [Enter only one couse per line for (o), (b), and (c)]					
ii o iii a		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BYONCHOPNEUMONIZ					
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e Program		Conditions, if any, which 16]					
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# 40% =	MEDICAL	Hour e, m. While Not while factory, street, office bidg., etc.]					
and	2	p. m. 19 et work at wark					
A S S S		21. I certify that I took charge of the remains described above, held an Autopsy . Inspection . Inquiry . and in m					
e Se e		apinion deoth resulted from: Notural couses 🔀, Accident 🔲, Suicide 🔲, Hamicide 🔲, Undetermined monner 🔲					
₹ ° 5 ° °		1 01 P P D D D D D D D D D D D D D D D D D					
i ed		SIGNATURE SIGNED MD. CHIEF MEDICAL EXAMINER [] C/MI) MD. CHIEF MEDICAL EXAMINER					
A gue		ASSISTANT MEDICAL EXAMINER []					
HR HE		NAME (Type) CON (C T) (C T) (C T) (C T)					
Cotton Court	270	BUR AL CREMATION, 27b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (C ty. town, or county) (State)					
D A A C O		Burial Jan. 20,1959 Free Will Baptist Bel Air, Harford, Maryland.					
7 5	23.	FUNERAL DIRECTOR'S SIGNATURE 240. REC'D BY REGISTRAR S SIGNATURE					
VS A15ME	1	Yours Abingdon, Maryland. DATE JAN 22'59					
5M 2/57	1	TO VICE TO THE TOTAL TOTAL TO THE TOTAL TOTAL TO THE TOTAL TO THE TOTAL TOTAL TOTAL TO THE TOTAL TOTAL TOTAL TO THE TOTAL					
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E () ()			MEDICAL EXAMINER'S CERTIFICATE OF DEATH #10696
HEALTH	DEPT.	==	Reg. Dist, No.
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Page Page			Guy Newell Marion Goneo
Signal A			WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address I (If yes, give wer or doles at service)
S. S. Swith		-	18 CAUSE OF DEATH [Enter only one course per line for (o), (b), and (c)] 18 CAUSE OF DEATH [Enter only one course per line for (o), (b), and (c)]
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irak endi al Eu sed		18	PERFORMED? YES \(\) NO \(\)\(\)
s certifiand "p Medical Nd be a riol, cr		CERTIFICATION	20a. EXTERNAL CAUSE WAS PRIMARY D or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Port II at item 18) And Cause of Death.
hief hief shaul			20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City of lown) (County) (Stute)
NEW THE CASE OF TH	12.	MEDICAL	8 Hour p. m. 1-6 197 While at work 10 of work 10 2 Street, office bldg, etc.) Concurse Hayerd Mil.
AMI Mrtiji ta ti Pag			21. I certify that I taok charge of the remains described above, held an Autopsy [], Inspection [], Inquiry [], and in my
ded ded			opinion death resulted fram: Natural causes
EDICA DIRECTOR			ACTUAL SIGNATURE LEVALUE C Jalmen M.D. CHIEF MEDICAL EXAMINER BOI A: 1, MCV. DATE SIGNED
orry Me the the tild be ERAL design			EXAMINER'S CONTROL COMMENT DEPUTY MEDICAL EXAMINER D
share its		220	BUR AL, CREMATION, 22b, DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (State)
5 , 4 5 9		23.	Burlal 1-10-59 East Brookfield Cem. East Brookfield, Vermont
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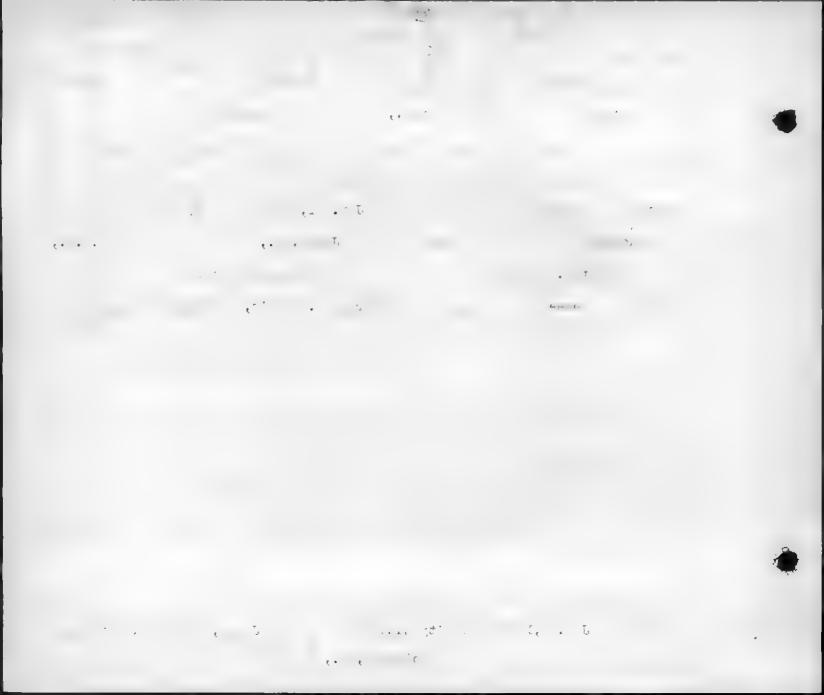
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 713

CERTIFICATE OF DEATH

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		PLACE OF DEATH		2 USUAL				ed. If institution Residence before admission)			
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		b CITY OR TOWN (If outside carporate limits, wr RURAL and give nearest town)	ite c. LENGTH OF STAY IN	1b c. CITY	OR TOWN (IF	outside corpo	role limits, write R	URAL and give	e nearest low	m)	
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		d NAME OF HÖSPITAL (If not in hospital, give st OR INSTITUTION	reet oddress)	d. STR	ET ADDRESS				ON	SIDENCE A FARM?	
		NAME OF DECRASED (Type or print) Christing	Middle	Norri	Last C	4. DATE OF DEATH	Jan Mon	499	Day	Year 19 5 9	
	5. 5		MARRIED NEVER MARRIED			1	9. AGE (In years	IF UNDER TY	EAR IF UND	1/ - 1	
			OWED DIVORCED [_	31. 18	80	last birthday)	Months Do	ys Hours	M+n	
		USUAL OCCUPATION (Give kind of work done	106 KIND OF BUSINESS OR I					12. CITIZE	N OF WHA	T COUNTRY	
		during most of working life, even if retired) Housewife	none						U.S.A		
	13.	FATHER'S NAME		none Joppa, Md.,				U.D.A.			
		Robert H. Lomyer	r		Marga	ret He	rbert				
	15. IYes	WAS DECEASED EVER IN U. S. ARMED FORCES?	16. SOCIAL SECURITY NO	17. INFORMANT			Addr	ess			
		no none	none	Charles	A. Nor	ris,	Edgewo	od Mar	yland		
		18 CAUSE OF DEATH [Enter only one cause p	er line for (o), (b), and (c)]						INTERVAL B	ETWEEN	
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		Conditions, if any, which (b)									
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	_	lying couse lost. (c)									
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	CERTIFICATION	206. ACCIDENT WAS UNDERLYING 206. OR CONTRIBUTING 206. (IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCU	JRRED (Enter nat	are of injury in I	Port 1 or Parl	I II of stem 18.)				
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		21. I certify that I attended the deci	eased from /2 4	·, 194	56 to 1	zn,	21, 1955	that I las	t saw the	decense	
	П	alive an 12h. 19 , 1	9.5.9 and that de	ath accurred	C7 6	C.	the causes a				
i		1.1.00					reet, city or town,			ATE SIGNE	
		SIGNATURE William W.	1 you	M.D.	/	Ting	150//14-	Md	,		
S. Martine		PHYSICIAN'S William	A. Tyson			1		7	24.2	-1,145	
	220	BURIAL, CREMATION, 226. DATE THEREOF	22¢ NAME OF CEMETER	RY OR CREMATO	Υ	22d. LOCAT	ION (City, fown, o	or County)	(Sto	te)	
		Burial Jan. 24, 1959	Trinity Lu	theran		Jopp	a, Harf	ord, Ma	arylan	d	
	23.	UNERAL DIRECTOR'S SIGNATURE	ADDRESS			D BY REGIST	RAR 24b. REGIS	TRAR'S SIGNA	ATURE		
	1	HOWING I MIKIMA	Abin	gdon,Md.	DATE JA	N 2 7 '5	9 (7)	FINT & A	- WA		

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the meral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death. eath. Page 4 TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs TO HOSPITAL OF VS A15 (4) 15M 10/57



DATE T

death

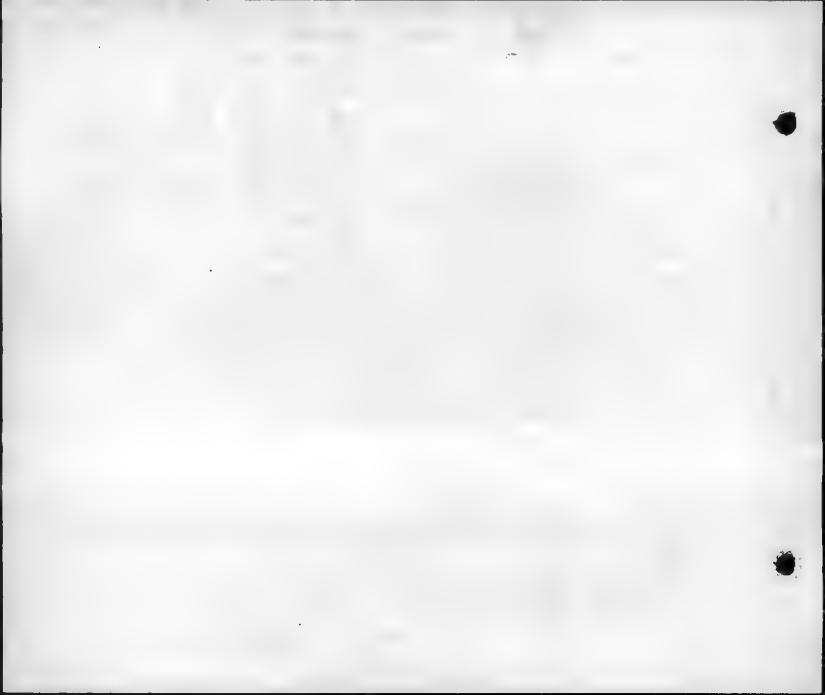
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688 **CERTIFICATE OF DEATH** Rea. Dist. No. il director, filed with 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) D. COUNTY b. COUNTY MARYLAND D.a CITY OR TOWN I Foutside corporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If obtside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) 200 d NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE OR INSTITUTION ON A FARM? 67 YES NO IN pup .5 3. NAME OF First 4. DATE Middle Month Day Filled DECEASED OF (Type or print) DEATH 195 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER I YEAR IF UNDER 24 HRS 8 DATE OF BIRTH 9 AGE (in years last birthday) Months Doys WIDOWED D DIVORCED T YES. 10a USUAL OCCUPATION (Give kind of work done) 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? death during most of working life, even if retired) and Domesti ofter 3. FATHER'S NAME physician 8 mave hours Address 560 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANI rending 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH ā PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) erebra DUE TO à Conditions, if ony, which (b) gave rise to immediate ĕ DUE TO couse (a), stating the underlying couse lost. erio Scierosis PART II. OTHER SIGNIFICANT COND TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(p) 19. WAS AUTOPSY PERFORMED? CERTIFICATI YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) certificate 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day. Year 20d. INJURY OCCURRED (County) (State) foctory, street, office bldg., etc.] While Not while at work of work O. 170 21. I certify that I attended the deceased from Jan. 20 , 1959, to Jan. 23 , 1959, that I lost saw the deceased and that death occurred at 7:30A. M. from the causes and on the date stated above. olive on 080 ADDRESS (Street, city or town, state) ACTUAL SIGNATURE M.D. 569 Revolution St. Houre de Cirace, M Prior should PHYSICIAN'S NAME (Type) Teorge FUNER m 220 BURIAL CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City (Stole) REMOVAL (Specify) neters O ADDRESS 240. REC D BY REGISTRAR 24b REGISTRAR'S SIGNATURE VS A15 (4) DATE 15M 10/57

HOSPITAL

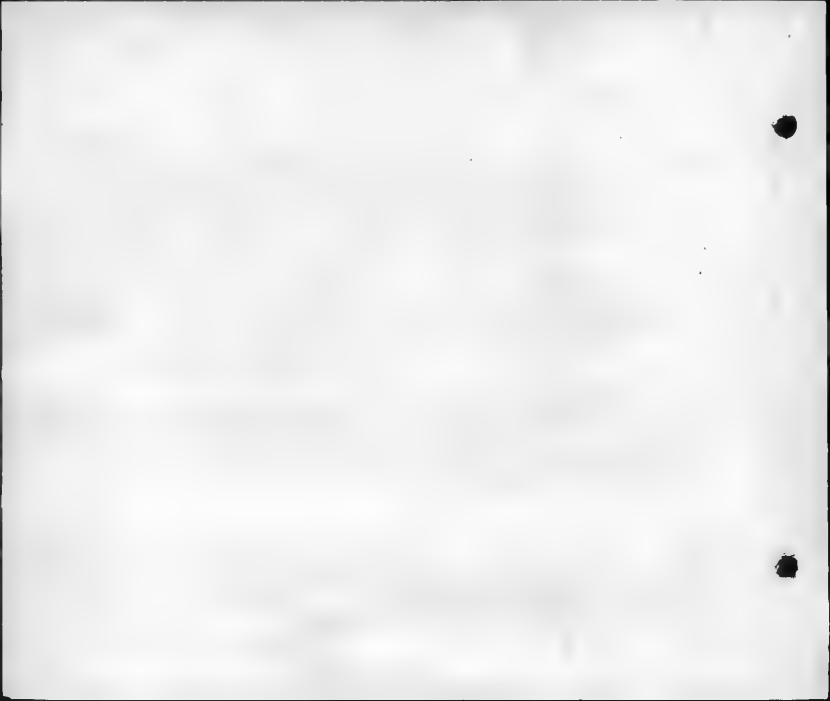
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



00780 689 **CERTIFICATE OF DEATH** Rea. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. COUNTY b. COUNTY 100 MARYLAND c. LENGTH OF STAY IN 15 b. CITY OR TOWN III outside corporate limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) å RURAL and give nearest town D d. NAME OF HOSPITAL (If not in bospital, give street address) .d. STREET ADDRESS e. IS RESIDENCE YES NO OR INSTITUTION NAME OF Middle 4. DATE last, Month Day Year DECEASED (Type or print) DEATH 5. SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE/(In years IF UNDER 1 YEAR IF UNDER 24 HRS (Miday) Months Doys Hours WIDOWED -DIVORCED papers. JOB USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? goring most of working life, even if retired) and Log ofter 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician ğ hours гетоме WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Addréss 18. CAUSE OF DEATH [Enter only one course per line for (o), (b), and (c) INTERVAL BETWEEN ONSEL AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chill **DUE TO** Conditions, If ony, which gove rise to immediate **DUE TO** couse (o), stoting the underlying couse lost. PART_II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS) PERFORMED? YES 🗍 NO P 200 ACCIDENT WAS UNDERLYING [] A 20b, DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port II or Port II of (tem 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (Stote) (County) oclary, street, office bldg., etc.) Hour 0. m of work at wark 19 That I last sow the degeosed 21. I certify that I ottended the deceased from total ond that death occurred .M, from the causes/and an the dote stated obove. OR -DATE SIGNED ACTUAL SIGNATUR 5 6 70 PHYSICIAN'S NAME (Type) FUNER 22b. DATE THEREOI 220. BURIAL, CREMATION, NAME/ OF CEMETERY OR CREMATORY (Stote) REMOVAL (Specify) 0 23. ELINERAL DIRECTOR'S SIGNATURE 24b REGISTRAR'S SIGNATURE DEY REGISTRAR 15M 9/59

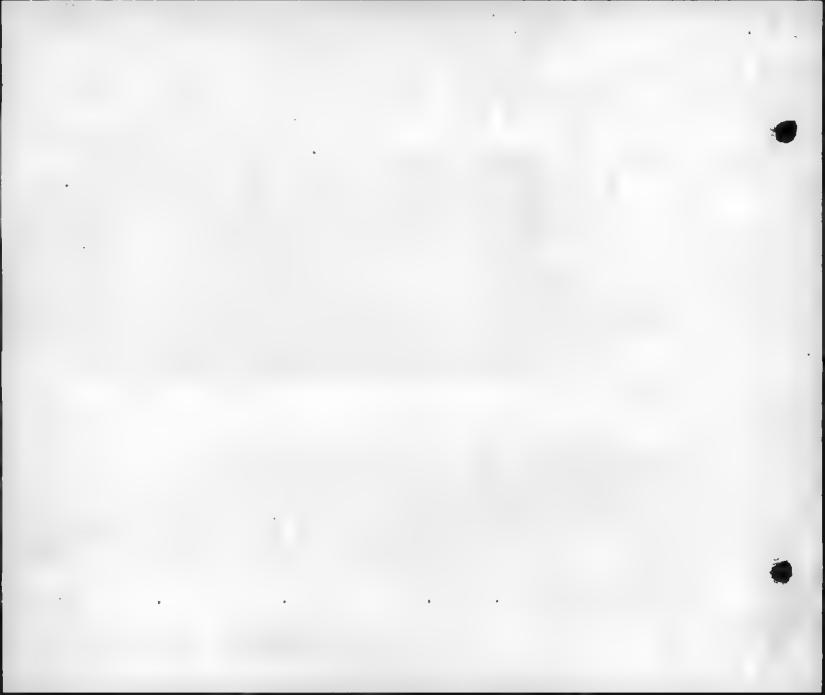
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



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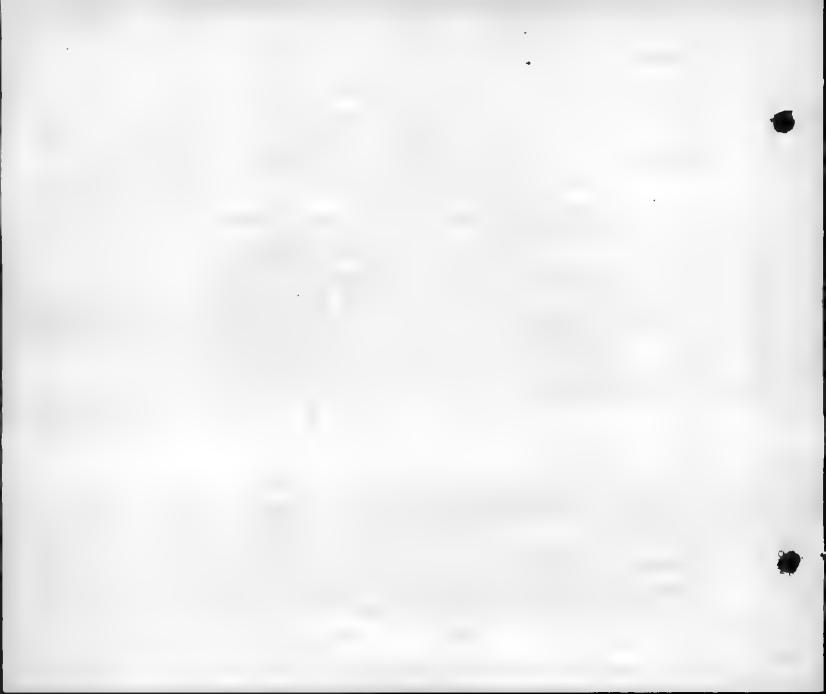
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** Reg. Dist. No. director, iled with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) filed a COUNTY o STATE b. COUNTY MARTIMANI unerol b. CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and girls nearest town) be 2 d. NAME OF HOSPITAL (If not in haspital, give street address) STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO NAME OF Middle 4. DATE Day DECEASED OF (Type or print) DEATH 6. COLORIOR RACE IF UNDER I YEAR IF UNDER 24 HRS 7. MARRIED | NEVER MARRIED | B. DATE OF BIRTH AGE (In years lost bighday) Manths Davs DIVORCED I WIDOWED 🔽 yrs 10a USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIJTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during mod of working life, even if relired) Ö 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician move 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o). **DUE TO** hot Conditions, if any, which gave rise to immediate DUE TO couse (a), slaling the underlying cause last, § PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 206 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e PLACE OF INJURY (Home, farm, 20f (City or lawn) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) Hour a.m. While Nat while of work of work p. m. to JAN 12, 1959 that I last saw the deceased 21. I certify that I attended the deceased from, alive on JAA and that death occurred at // A.M. from the causes and on the date stated above. ADDRESS (Street, acity or towny stole) **ACTUAL** SIGNATURE shauld PHYSICIAN'S WEISS. ANDRE MD. Air Ave. NAME (Type) January 220. BURIAL, CREMATION, 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or sounty) 10 FUNCTIAL RECORDESTRAR 24b. REGISTRAR'S SIGNATURA VS A15 (4) 1 relier S. Firsus 15M 10/57



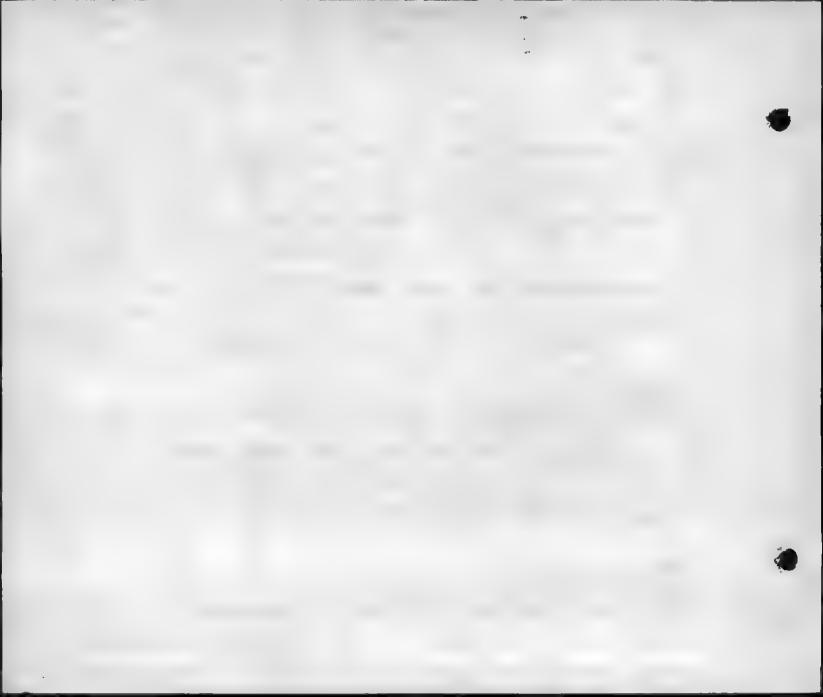
death

hours



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 690 **CERTIFICATE OF DEATH** Reg. Dist. No. director, Affed with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b COUNTY OF TOWN (If outside corporate limits, write ENGTH OF STAY IN 16 c CITY OR JOWN (If outside corporate limits, write RURAX and give negrest lown) d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO P 3. NAME OF Middle 4 DATE Lost Yeor Month DECEASED DEATH (Type or print) 19 9. AGE (In years lost b rthday) 6 COLOR OR RACE 7. MARRIED ZI-NEVER MARRIED 8 DATE OF FUNDER TYEAR IF UNDER 24 HRS camplete Months Doys Hours WIDOWED | DIVORCED 10a. USUAL OCCUPATION (Give Lind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT COUNTRY puo Leon 13. FATHER'S NAME MOTHER'S MAIDEN NAME remave IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address attending 18. CAUSE OF DEATH [Enter only one couse per line for (a). INJERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Sax DUE TO Conditions, if ony, which (b) gove rise to immediate **DUE TO** couse (a), stoling the underterios derosis lying couse lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPS) PERFORMED? YES NO 🗍 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) 20c. TIME OF INJURY Month, Doy, Year 20s. PLACE OF INJURY (Home, form, 20f. (City or town) 20d. INJURY OCCURRED (Stole) (County) Hour a.m. factory, street, office bldg , etc.) While Not while of work of work 21. I certify that I attended the deceased fram. 1952, that I last saw the deceased and that death occurred at 9:00 A.M. from the causes and an the date stated above. alive on ACTUAL SIGNATURE DIRE ā P 3 shoul PHYSICIAN'S FUNERAL NAME (Type) xeoro 220 BURIAN CREMATION, 226 DATE THEREO! 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (C ty. lown, or county) (Stote) REMICVAL (Specify) the 24b. REGISTRAR'S SIGNATURE 24a. REC'D BY REGISTRAR VS A15 (4) DATE JAN 9 Circums S. Hinsed 15M 10/57





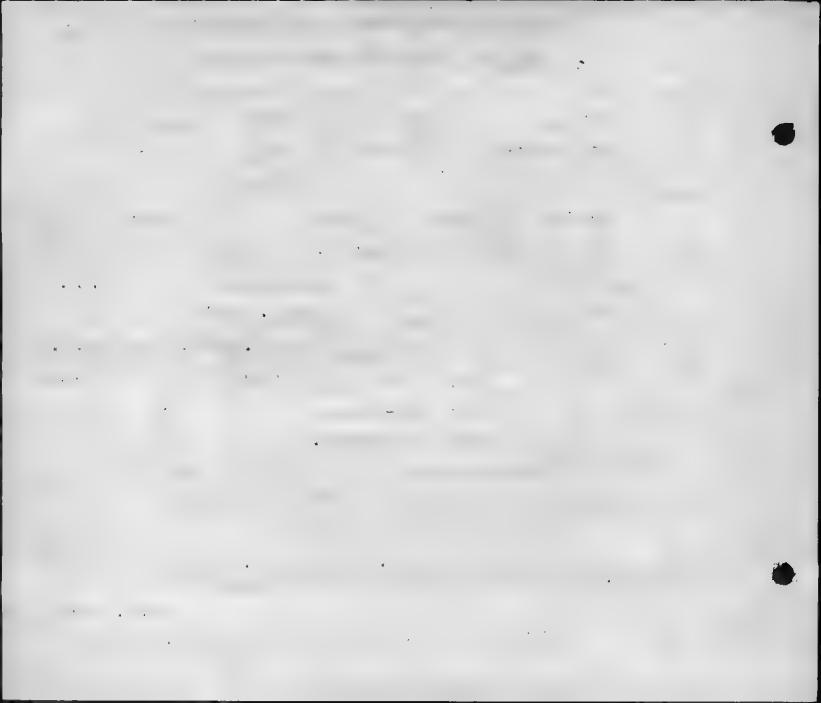
The Bottom copy may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00706

713 CERTIFICATE OF DEATH

-							eg. Dist. No.	***************************************
1. PLACE OF	DEATH				2. USUAL RESID	ENCE (HOME) OF D	ECEASED	
	Harford		MARYLAI	ND D	STATE Maryla	and COUNTY	Harford	
CITY (If out:	side corporeta limits, write ive nearest town)	RURAL	LENGTH OF S		CITY (Il autside cor OR	rporete limits, write RURAL a	and give neerest lowr	1)
TOWN	Rural Bal	440		years	TOWN	al Bel	A of ma	
HOSPITAL OR				30020	y STREET	SLI DO I	va location)	
INSTITUTION STREET ADDRE					ADDRESS			
3, NAME OF	(First)		Middle		(Lest)	bson A. DATE (Mo	nth) (Day)	(Year)
DECEASEI (Type or Print)					,	OF	, , , , ,	(4 m m 1)
S. SEX	Mannie	7. SINGLE, MARRIE	Leve	8. DATE OF	odes	9. AGE lest birthdey	ADDIATE THE T	IIF UNDER 24
J. 25.	RACE	WIDOWED, DIV	ORCED,				Months Days	Hours A
Female	White	Married		Januar	7 15.1893 BIRTHPLACE (State or to	65 yrs.		
done during s	JPATION (Give kind of w most of working his, ever	ork iQb, KIN orid OR	D OF BUSINESS	រា	BIRTHPLACE (State or to	reign country)		EN OF WHAT
relired)	lousewife				North Caro	lina		S.A.
13. FATHER'S NA	ME				14. MOTHER'S MAIDE	N NAME		
	rd Wood				Deame J.	Baldwin		
15. WAS DECEAS	ED EVER IN U. S. ARMET		SOCIAL SECUR	ITY NO.	17. INFORMANT 8	ADDRESS		
(Yas, no, or unk.)	(H Yas, give wer or det	as of service)			Thomas	E. Rhodes, F	oract H47	1 1/4
ANTI DISEASES OR CO GIVING RISE TO STATING UNDERL II OTHER SIGNIFIC TO THE DEATH	ONDITIONS, IF ANY, THE ABOVE CAUSE VING CAUSE LAST. CANT CONDITIONS CON- BUT NOT RELATED TO TH	(B) Chron (C) Chro (RIBUTING		0=458C		pertension ;		minutes years
DISEASE OR CO	NOTION CAUSING DEAT		0.5 0.550 4.750 4.75					
170, DATE OF OP	EKATION ISB.	MAJOR FINDINGS	OF OPERATION				YES	O. AUTOPSY?
OR CONTRIBUTING	VAS UNDERLYING	21b. PLACE (Home OF INJURY street, o	o, farm, factory, office bldg., elc.)	210	. WHERE DID INJURY OCC	CUR? (City or town)	(County)	(State)
21d. TIME OF INJE	URY (Month) (Dey) ((ear) (Hour) 21s. While M. at we	INJURY OCCURR NoI work et wo	hile -	f. HOW DID INJURY OCC	CUR?		
22. I hereby	certify that I att	anded the decea	sed fromച	an.	19.53 to Ja	n. 19.59.	that I last sa	w the decea
alive on I	Dac. 31 19		that death of	courred at.	LO.100.M, from the	causes and on the DRESS (Street, city, lov	date stated abov	ve. DATE SIGI
23. BURIAL, CREA		THEREOF		M.D. METERY OR C		Forest Hi		nuary 2
Buria		3/59	Oak Gr	ove Bar	tist	Bel Air,	Waryland	
24. REC'D BY REC	, ,	TRAR'S SIGNATURE			25. FUNERAL DIRECTOR	SSIGNATURE	ADDRES	5
DATERAN 5	59	7,86			They Is	Red Bel	cu Th	2



VS A15 (4) 15M 9/55

ARYLAND	STATE DEPARTMENT	OF HEALTH-BALTIMORE,	18
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691 CERTIFICATE OF DEATH

00707

Reg. Dist. No. . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b. COUNTY frick MARYLAND b. CITY, OR TOWN (If outside carparate limits, write c. LENGTH OF STAY IN 16 c. CITY QR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest town race d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e, tS RESIDENCE ON, A FARM? OR INSTITUTION YES NO I 16 SIDE NAME OF 4. DATE Pirst Middle Month Year DECEASED Of (Type or print) DEATH 19 3 MLC GIL 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX DATE OF BIRTH 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS last birthday) Months WIDOWED [DIVORCED TO Mario 10g. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY, 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? during mast of warking life, eyen if retired) 13 FATHER'S NAMI 14. MOTHER'S 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause lost. 10 Hypertensive - Arterio sclerotic Heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth. 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, 20f. (City or town) Day, Year (Stote) (County) factory, street, office bldg . etc.) Hour om While Not while at work of work 19.58, to 1/27 1952, that I last saw the deceased 21. I certify that I attended the deceased from ___ 10 alive on, and that death occurred at 12:00...M. from the causes and an the date stated above ADDRESS (Street, city ar town, state) DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Coro C DATE THEREO 220. BURIAL CREMATION. NAME OF CEMETERY OR CREMATOR 22d. LOCATION (City, fown, or county) (Stote) REMOVAL (Specify 246 REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE 240 REC'D BY REGISTRAR



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

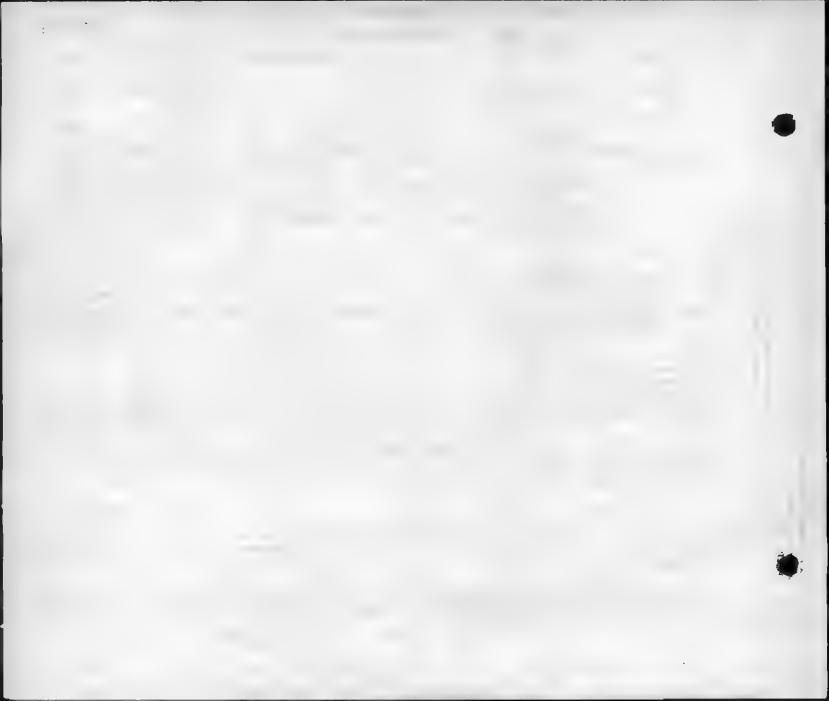
692 **CERTIFICATE OF DEATH** 1111768

				. Dist. 110.
o. COUNTY Harvord	MARYLAND	2. USUAL RESIDENCE (Where dece	osed lived. If institution, Res	desce before admission)
b. CITY OR TOWN If autside corporate limits, write RURAL and give nearest town	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside co)	and give nearest town)
d NAME OF HOSPITAL (If not in hospital, give street a OR INSTITUTION OF INSTITUTION OF THE TAXABLE AND AND A STREET OF THE TAXABLE AND A STREET OF TAXABLE	ospetal	734 Utsego	St.	ON A FARM? YES NO
NAME OF DECEASED (Type or print) Olivia	Middle Ki	chardson DEA	TH Januar	
male regro widows	D DIVORCED	7-12-1893	lest (lirthday) Mont	251
a. USUAL OCCUPATION (Give kind of work done lob.) during most of working life, even if retired)	esapeake Hote	1 Harford Com	ty Hed	U. J. A
Hoyd Richards	n	Elizabetto	Bowse	N.
es. no. or unknown) If yes, gave wor or dates of service	77	150 Lewis V. Ri	chardon - 1	Lavele Bure
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LLLL 3 X DUE TO	e for (a). (b). and (c).)	et Failure		INTERVAL BETWEEN ONSET AND DEATH
Canditians, if ony, which gave rise to immediate cause (a), stoting the under-lying cause last.	rtensive-Arten	esclentic Heart	disease	
PART II. OTHER SIGNIFICANT CONDITIONS CO	ONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DIS	EASE CONDITION GIVEN IN	PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
200 ACCIDENT WAS UNDERLYING 20b. DESC OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	RIBE HOW INJURY OCCURRED). (Enter nature of injury in Port I ar	Part 11 of item 18)	
Hour a.m. While		CE OF INJURY (Home, farm, 20f. (tary, street, affice bldg., atc.)	City or town)	(County) (State
21. I certify that I attended the decease alive an		19.53% to //		t I last saw the decease
ACTUAL SIGNATURE SOFTER J. Sta	0		(Street, city or town, state)	DATE SIGN
PHYSICIAN'S GEOVOET. Stup	sbury			
8. BURIAL, CREMATION, 226. DATE THEREOF REMOVAL (Specify) 1-10-59	22c. NAME OF CEMETERY OF	Cemetery Dy	avre de	Prace d
Funer Bullock	Hane de	Sluce Head DATE , IAN 1 3	CISTRAR 246. REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after death. Page 4 may be retain.

OR: After this certificate has been signed by the attending physician and completely filled in by uneral direpage 3 should be detached for use as the buriot-transit permit. Then please remove carbon popers. Pages 1 and 2 should be filled the registrar prior to buriot, cremation, or removal, and in any event within 72 hours after death. may be retain TO FUNERAL DI VS A1S (4) 15M 9/5S

uneral director.



Rea. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY **b.** COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write E. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest town) URE de SIEBO d. NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO NAME OF 4. DATE Middle Last Month Day Year DECEASED (Type or print) DEATH 195 anuaR 5. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED NGE (In years lost b rthday) IF UNDER 1 YEAR IF UNDER 24 HR B DATE OF BIRTH Months Dovs Hours DIVORCED [WIDOWED TH 2MAI 00 USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTR 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) MINDEN1175 13 FATHER'S NAME MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) D **DUE TO** Conditions, if ony, which gave rise to immediate **DUE TO** cause (o), stoting the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO ! 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, | 20f (City or town) (County) (Stote) foctory, street, office bldg , etc.) Hour o. m. Nat while of work of work 21. I certify that I attended the deceased from. ____, 19____,that I last saw the deceased _, and that death accurred at 1.45 alive an_ F.M. from the causes and an the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL SIGNATURI PHYSICIAN'S NAME (Type) 220 BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (Csty, town, or county) (Stote) -REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 246 REGISTRAR'S SIGNATURE 24a, REC'D BY REGISTRAR & inous

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deoth, Poge



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 OUZEA **CERTIFICATE OF DEATH** 720 Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o. COUNTY b. COUNTY MARYLAND Harford Marvland Harford b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest lawn) RURAL and give nearest lawn) 14 vrs. Joppa. d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS e IS RESIDENCE 00 OR INSTITUTION ON A FARM? á YES NOX 2. NAME OF First 4. DATE Middle Last Month Day Year DECEASED (Type or print) DEATH Charles Anderson 1950 Seaman Jan IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7 P. AGE (In years MARRIED TO NEVER MARRIED B. DATE OF BIRTH lost birthday) Months Days Hours Min DIVORCED T male white WIDOWED | 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) carban r U.S.A. Motorman Transportation New Jersev 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME physician Charles T. Seaman move o Laura Anderson IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 14. SOCIAL SECURITY NO. 17. INFORMANT Address 215-09-3632 Mrs. Barbara W. Seaman yes Joppa. Marvland CAUSE OF DEATH [Enter only one couse pegaline for (o), (b), and -(c).] INTERVAL BETWEEN ۵ ONSET AND DEATH PART I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO couse (o), stating the underlying sause lost. (c) CATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19, WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) WEDICAL 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Hame, farm, Day, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (Stote) factory, street, office bldg., etc.) Hour Q. f1. While Not while at work at work p. m. 21. I certify that I attended the deceased from 12 19,27 that I last saw the deceased 17M. from the causes and an the date stated above. alive an A_, and that death accurred at/c30 ADDRESS (Street, city or lawn, stafe) **DATE SIGNED** Colobe SIGNATURE may be retained FUNERAL Di 3 should TO HOSPITAL PHYSICIAN'S Edgewood, Maryland, NAME (Type) Louis. E. Kahan 22a. BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) page (State) REMOVAL (Specify) Burial Jan. 15/1959 Bel Air Memorial Gardens Bel Air, Harford Maryland. 0 23, FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Abingdon, Md., JAN 1 6 '59 Es Thurs S. Make VS A15 (4) DATE 15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** 721 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)

00712

Reg. Dist. No.

d. Cooler	Harford		MARYLA	ND	Mary	zlan	d	b. COUNT	,	Harf	ord	
b. CITY OR TOWN (RURAL and give of Joppa		ts, write	c. LENGTH OF STAY IN		c. CITY OR TOWN		tside corpo	rote limits, write	RURAL ond			
	TAL (If not in hospital, g	ive street			d. STREET ADDRE		, Da				S RESIDE	ARM2
NAME OF DECEASED (Type or print)	Fir		Middle		Lost		4. DATE OF DEATH	Mo		Day	Yeo	
. SEX	6. COLOR OR RACE		U a		Sparks B DATE OF BIRTH		DEATH		Jan.	R 1 YEAR IF	19	
			IED NEVER MARRIED	_		100		9. AGE (In years lost birthday)	Months		ONDER 2	Min.
Male	White	WIDOWS	-	_	July, 15,			76 yrs				
during most of wor	Ving life, even if retired	done 10b.	KIND OF BUSINESS OR I	NDUS	TRY 11. BIRTHPLACE (Stote o	r foreign o	ountry)	12. C	ITIZEN OF V	VHAT CO	DUNTRY?
Farme	r		Owner		North			1		U	.S.A	
3. FATHER'S NAME					14 MOTHER'S MAID	DEN NA	ME					
William	Spark				Mary Mo	xle	v					
	R IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17. 10	NFORMANT			Adi	iress			
no	(ii yes, give wor or other or s	irresco)	none	Mars	s. Clittis	Mox	lev.	Toppa. N	aryla	മെർ.		
	ATH [Enter only one co	use per lir	ne for (a), (b), and (c).]	2.04	/	11011		1	1		AL BETW	/EEN!
	ATH WAS CAUSED BY:		Fridoricapl	. 2 0.	Hea Cirches	AN	AAA.	Varan	1	ONSET		
11001	IMMEDIATE CAUSE (o		JOROVOVECE	v.	THE COURSE	700	<u>van</u>	ransen	4			
420.1	DUE TO		Cardina	A 4	a. O. 1 6	2	200	1 2				
	Gonditions, if any, which gove rise to immediate (b).											
couse (a), stating lying couse lost.)	C.V.A.									
PART II. OTI	HER SIGNIFICANT CON	DITIONS C	ONTRIBUTING TO DEATH	BUT	NOT RELATED TO THE I	TERMIN	AL DISEAS	E CONDITION GI	VEN IN PA	RT 1(o) 19. V	VAS AU1	TOPSY
[1001100	A)	110						ERFORM	
OR CONTRIBUTING	200, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH OF THE NOTIFY MEDICAL EXAMINER!											
20c. TIME OF INJUR		- 100 4 44	IIIInu - decinose De	- 01.4	CC 0C 10 1111001 111		last in					
Hour o. n.		While	Not while	foci	ICE OF INJURY (Home, tory, street, office bldg.	. form,	20f. (City	or town)		(County)		(Stote)
p. m.	19	at worl										
21. I certify th	at, I attended the	decease	ed from 1/7		19.57. to		1/16	. 195	that I	last saw	the de	reased
alive an	1460	. 19	57 And that de	eath	accurred at 419	4	M from					
(1720	c-1			Jacon Con Contract			reef, city or town.		me dules	DATE	AIGNIO
TURE	Dem	15	han	A	4.D. JAC	96	6 8	delu	TOO,	A.,,		4
PHYSICIAN'S NAME (Type)	E. Louis	Kaha	1		Edge	rood	Max	yland		./	(
2a. BURIAL, CREMATIC		F	22c. NAME OF CEMETE	RY OR	CREMATORY	2	2d. LOCAT	ION (City, town,	or county)		(Stole)	
REMOVAL (Specify) Removal	1/18/19	59	Moody Fune	ral	1 Home			t Airy,				
. FUNERAL DIRECTOR	'S SIGNATURE //		ADDRESS	-		REC'D	BY REGIST			IGNATURE	-	
Jourse	K. M. Con	unX	/ Abingdon,	Ma		.1/	IN 2 0		10 1 11	S. France	čt.	
7 17												

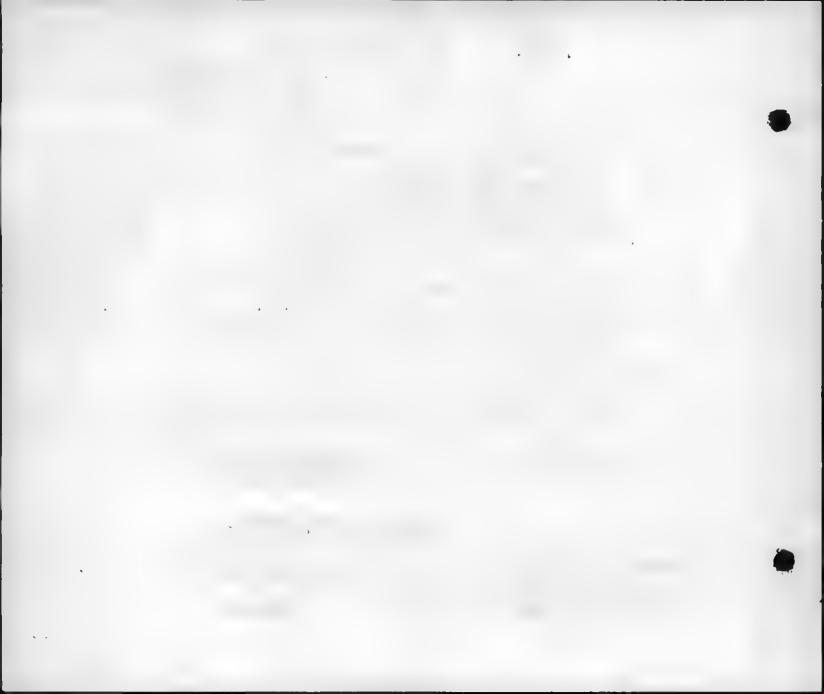
eral director, be filed with requires that the death certificate be executed within 24 haurs after death. Page the hospital or attending physician.

OR: After this certificate has been signed by the attending physician and campletely filled in detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and ta burial, cremation, or remaval, and in any event within 72 haurs after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law TO FUNERAL DIR page 3 shauld be d VS A15 (4) 15M 9/55

1. PLACE OF DEATH

217

r T (* " - ' . (Jing , , , , , , 2 " " " S. Last. 1956 gg. e e



meral director, d be filed with

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 695

CERTIFICATE OF DEATH

00714

Reg. Dist. No.

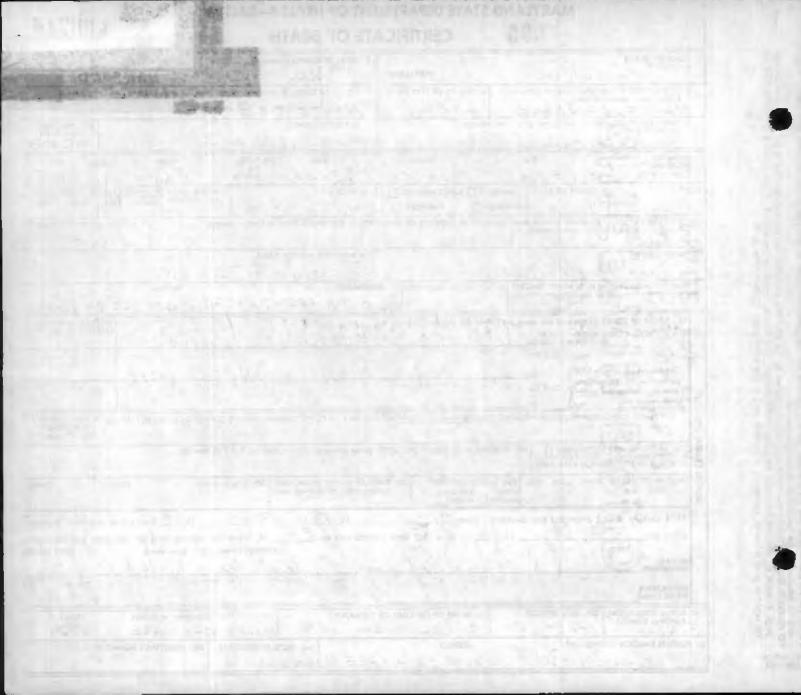
	1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
	O. COUNTY HARFORD MARYLAND	O. STATE M.D. b. COUNTY HAR FORD
	b. CITY OR TOWN (If autside corporate limits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside carparate limits, write RURAL and give neatest town)
	HAVRE DEGRACE LIFE	HAVRE DEGRACE
	d. NAME OF HOSPITAL (If not in hospital, give street pridress)	d. STREET ADDRESS e. IS RESIDENCE
3	801 DUTARIO ST.	801 ONTARIO ST YES NO B
	3. NAME OF First Middle	Last 4. DATE Month Day Year
	(Type or print) KATHERINE FRANCES	WERNER DEATH JAM. 1/ 1959
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Manths Days Hours Min.
	FEMALE WHITE WIDOWED DIVORCED	MAR, 26, 1974 84 YO.
-	10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDU- during most of working life, even if retired)	STRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY:
	HOUSE WORK HOME	Mp U.S.A.
	18. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
1	JOHN WERNER SR.	ITEGINA SITZLER
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I	NFORMANT Address
	- Mh	A. HUGHES OPENCER, HAVRE DEGRACE MO.
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	TARA INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY:	verilla andias
	4 d d, DUE TO	
	Conditions, if any, which) (b) 10 10 10 10	To Mark In Mal
	gave rise to immediate couse (o), stating the under DUE TO	The contract of
	lying cause last. (c)	
2	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
2	3	YES NO
	Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 206. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	D. (Enter nature of injury in Port I or Part II of item 18.)
	3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, form, 20f. (City or town) (County) (State)
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while for work of work of work	clary, street, affice bldg., etc.)
	214	20 11V: TON 11 2050
	21. I certify that I attended the deceased from	19 45, to TAN-11, 1959, that I last saw the deceased
	alive on 19 grid that death	accurred at 3 A. M. from the causes and an the date stated above
	ACTUAL OF THE STATE OF THE STAT	CX 10 M les Ballet de Dili 1
	SIGNATURE	M.D
	PHYSICIAN'S NAME (Type)	2/1/19
	220. BURIAL, CREMATION, 226. DATE THEREOF 22C. NAME OF CEMETERY OF	R CREMATORY 22d. LOCATION (City, town, or county) (State)
	REMOVAL (Specify)	CREMATORY (State) (State) (State) (LL CEIVI, HAVRE DE GRACE MD.
	23. FUNERAL DIRECTOR'S SIGNATURE Y ADDRESS	24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
	XIII adison Metchell HAVRE DE GR	ACE MADATE JAN 1 4 59 arthur S. France

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. Page may be retained the haspital or attending physician.

TO FUNERAL DIR.

OR: After this certificate has been signed by the attending physician and campletely filled in by it page 3 shauld be detached for use as the burial-transit permit. Then please remare carbon papers. Pages 1 and 2 shouthe registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death.

V\$ A15 (4) 15M 9/55



certificate be executed w

this

1. PLACE OF DEATH

TOWNTROCKS

HOSPITAL OR

3. NAME OF DECEASED

13. FATHER'S NAME

5. SEX

COUNTY HATFOTO

INSTITUTION OR KOULE

(If outside corporete limits, write RURAL end give necrest town)

(First)

(If Yes, give wer or dates of service)

JAMES

COLOR OR

RACE

10e. USUAL OCCUPATION (Give kind of work

relired) FARMINA

SAMUEL

done during most of working life, even if

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

IMMEDIATE CAUSE ANTECEDENT CAUSE(S)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

19a. DATE OF OPERATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

NSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Wilson

B. DATE OF BIRTH

20

11. BIR

TY

14.

2.

CERTIFICATE O 723

MARYLAND

LENGTH OF STAY (in this placa)

(Middla)

10b. KIND OF BUSINESS OR INDUSTRY

NONE

196. MAJOR FINDINGS OF OPERATION

21b. PLACE [Homa, farm, factory,

OF INJURY streat, office bldg., atc.)

16. SOCIAL SECURITY NO.

MALNUTRITION

18. MEDICAL CERTIFICA

FARMET

SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WidowEd

LEMS

00715

L DE		eg. Dist. No.	*********************
SUAL RESIDE	NCE (HOME) OF D	ECEASED	
TATE MPTON	Prod COUNTY orate limits, writa RURAL a	Harford	
OWN Rock		ing give heerest tow	1)
DDRESS Roul	HE #24	va location)	
	4. DATE (MO OF DEATH J	ANO 8	(Year) 1959
,1874	9. AGE last birthday 84 yrs.	Months Days	Hours Min.
HPLACE istate or fore		COU	EN OF WHAT
	We Aliste,	-	
TOPUCES	No HINCE, R	ocks , M	myland
TION		INI	ERYAL BETWEEN
D Pulma	VARY EDEN	nA .	2 WKS
			sto 8 mes
O SCLEROT	DISEASE	- Vascular	OVER 1041
		YE:	O. AUTOPSY?
RE DID INJURY OCCL	JR? (City or town)	(County)	(Stata)
V DID INTERV OCCI	ID 2		

(IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. TIME OF INJURY (Month) (Day) 21a. INJURY OCCURRED 21f. HO While Not while at work 22. I hereby certify that I attended the deceased from JAN 8, 19 alive on JAN 7 , 19.59 and that death occurred at 6.50PM, from the causes and on the date stated above. ADDRESS (Straal, city, town, state) DATE SIGNED M. D. 23. BUE

Zic. WH

Philipsel	Human	
BURIAL, CREMATION, REMOVAL (SPECIFY)	JAN. 10, 1959	

NAME OF CEMETERY OR CREMATORY Itoly Cross Episcopal CEMETERY Kocks,

LOCATION (City, town, or county)

24. REC'D BY REGISTRAR DATE JAN 1 2 '59

REGISTRAR'S SIGNATURE a thung & thouse

25. FUNERAL DIRECTOR'S SIGNATURE W. Brondway + Williams St. BEL Air, Maryland

after de this After the third copy of the 72 hours after funeral funeral by the f 후 .드 with filled complittely TO FUNERAL DIRECTOR: The law requires that the death certificate be certificate has been executed by the attending physician and complised death certificate assembly should be detached for use as a burial transvs AISC 1-55 10M. or all anding physician.

PHYSICIAN OR HOSPITAL: The law requires that the The bottom copy may be retained by the hospital CHI DOOR WARE-HILLARY TO THEM SALUD WATE CHAPTERED CERTIFICATE OF DEATH CONTRACTOR OF THE PARTY Control of the second of the s